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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, JANUARY 6, 1909.

No. 1.

# Notes and Comments.

At a City inquest last week, the Experiments Coroner very properly drew attention to a fact which we think should be understood in all its bearings. Patients. The institution at Battersea which rejoices in the title of the "Anti-Vivisection Hospital," was called upon to treat a little girl who had an injury to the head. The wound was examined by the resident medical officer, a gentleman who has been qualified for close on thirty years, and stitched up by a nurse. Somehow or other the child appears not to have attended frequently, and some weeks later she was admitted to St. Bartholomew's Hospital with cerebral abscess, a condition which, in spite of operation, eventually proved fatal. We do not wish to deal with this aspect of the question, but to the one which struck the Coroner, namely, that on the annual report of the Anti-Vivisection Hospital appeared the words, "No Experiments on Patients." The secretary, when questioned as to the meaning of this phrase, said that the poor were often shy of hospitals, and denied that it suggested that experiments were performed on patients at other hospitals. The solicitor who appeared for the hospital admitted that he had heard it said that surgeons liked to try experiments on poor patients in hospital, and the matter seems to have stopped at that.

on the Public.

WE think the Anti-Vivisection Hospital is very lucky to have got out of the quandary so easily. The title "Anti-Vivisection Hospital" either means that other hospitals are pro-

vivisection, or nothing. As a matter of fact, of course, no hospital qua hospital is vivisectionist or anti-vivisectionist, although in the schools attached to a few teaching hospitals experimental physiology and pathology is taught. If, however, any doubt existed as to the real meaning of the title, the printing of the words "No Experiments on Patients" would show what is intended. It is only en pièce with anti-vivisection methods that such a scandalous innuendo should be thrown out against the great charities of England. There can be no doubt in the mind of any impartial person what is intended by printing these words in the report, and we have no hesitation in saying that they stamp the institution as a disingenuous one in spirit and method. The experiment that is being made by it is an experiment on the credulity of the British public, and it is employing the most cruel and heartless manner of making it. The old lies put about by anti-vivisectionists about experiments on hospital patients have been exposed again and again, but the anti-vivisectionist hospital does not hesitiate to trade on the superstitions of the poor of Battersea.

Ad Nauseam. MR. COLERIDGE, who, to do him justice, has frequently repudiated the Batersea institution, has lately given another example of the same persistency in anti-vivisectionists

dishing up the same old story, which is shown to be untrue each time it appears in print. In the Times, last week, Sir Victor Horsley again took him to task for propounding the worn-out fable about Dr. Crile's experiments on shock. It may be remembered that, in order to determine certain points, at certain stages of some of the experiments the animals were allowed to come so far out of surgical anæsthesia as to show reflexes, though, of course, absolutely unconscious of pain. The terms "incomplete anæsthesia" and "light anæsthesia" were used to describe this condition, and Mr. Coleridge, seizing on these words, and knowing nothing about anæsthesia, has attempted to make capital out of them for nearly ten years. We hoped that his avaragement before the Basel Committee that his experience before the Royal Commission on Vivisection would have had the effect of sobering him and making him adhere more closely to fact, but even the pitiful figure he cut there seems to have left his faculty for distortion but little impaired.

Ambulance Training.

BEFORE leaving the subject of "experiments" on patients, it is well to notice the type of feeling on the subject which prevails even in certain educated people. The

Paddington Board of Guardians, a little while ago, passed a resolution allowing twenty men of the 1st City of London Field Ambulance R.A.M.C. to attend their infirmary to receive instruction in the application of splints and in the dressing of wounds, on the understanding that no patient was to be dressed by them without previously giving his consent. One guardian, Colonel Maunsell, strongly objected to the arrangement, declaring that patients should not be practised on, even with their consent, and another gentleman supporting him, the question is to be re-opened shortly with a view to rescinding the resolution. Now, it is hardly necessary to say that every proper step that can be taken to protect hospital patients—pauper or eleemosynary -should be taken, but it is equally obvious that unless would-be beginners practice on some such person they will never be beginners at all; and one generation will suffice to see the extinction of doctors and all attendants on the sick. Students and ambulance men must learn on someone, only they must do so under strict tutelage and supervision. Even at the Anti-Vivisection Hospital it would appear that nurses are allowed, under the medical officer, to sew up wounds, though that is the only institution we know of in London where

such a practice is permitted. So that if the Paddington Guardians do as they are asked, and go back on their resolution, they are likely to throw the wounded Territorial soldier of to-morrow into the hands of men who have never been taught to handle or deal with a sick man.

"Rotten,
Ripping, and
Right-oh!"

The benevolent and public-spirited gentlemen who sit on the Walsall Education Committee seem to take their duties so seriously that anything in the nature of pleasantry is

regarded as an offence against the decorum that should characterise that dignified body. The actual facts of the case are difficult to ascertain with accuracy, but Dr. Stead, Vice-Chairman of the Education Committee, seems to have pained his serious-minded colleagues by what one of them described as a "disgraceful attack on education." Mr. Leckie, the gentleman in question, was almost paralysed when he read it. "The doctor," he asserted, "had said he had no sympathy with algebra." It may be an unfortunate result of medical training, but we confess to having very little ourselves; but let us hasten to add, we hold the study in great veneration, perhaps all the more because of our own ineptitude for it. Still, we admit that a gentleman who can publicly proclain his distaste for algebra is just the sort of person who might be led into making disrespectful remarks on the equator. But had Dr. Stead stopped there he might have escaped the worst. Unfortunately, he angered his colleagues more by referring to the three R's as "Rotten, Ripping, and Right-oh," "a quotation," said his critic, "from a low-class journal." Dr. Stead, when he rose to reply, was unabashed, admitted his crimes, and said it was the first time he had heard Punch called a low-class journal. Verily, as Mr. Dooley has told us, a hard life is science.

The Rich
Kleptomaniac.

A RECENT police court decision by a metropolitan magistrate raises points that appear to deserve comment from the social as well as the medical point of view. Shortly before

cal point of view. Shortly before Christmas Day a lady visited certain stores, where she was detected in the act of carrying away a quantity of articles that had been stolen. culprit was defended in court by learned counsel. who stated that she was in affluent circumstances and occupied a good social position. It seems almost incredible that she was permitted to remain nameless throughout the trial by an Englishman occupying so responsible a judicial position as that of a London stipendiary. Yet that is what occurred, the defendant having been dismissed on payment of three guineas costs and on her medical man's recognisance of £20 for her appearance if called upon for judgment within twelve months. This leniency was apparently on the ground of mental irresponsibility for her actions, and she was allowed to leave the court without having disclosed her name and address from first to last to the police. This novel departure in the administration of a summary court may safely be left to the consideration of Parliament when it reassembles. In the case, say, of Jane Smith, of Leather Lane, she is liable to have her name and address published in full, not to mention her age, when brought before the magistrate for any offence whatever, no matter how venial or trivial. Why another female, having committed a felony, is to be allowed to conceal her name and address, simply because she happens to be wealthy and to live in Belgravia, is one of those mysteries of the law that at times spring up to perplex the popular mind. As a matter of fact, Mr. Francis, the magistrate in the above case, had two other charges of stealing from the same stores brought before him. One, a housekeeper, was sentenced to two months' imprisonment without option of a fine, and the second, a nurse, was remanded.

Why not a incident requires just as much unravelling. If a Belgravian lady Kleptomaniac? steals a number of articles suitable

for presents shortly before Christmas, there is a clear motive for the departure from the ethics of her class. If Jane Smith, of the address aforesaid; purloins a goose to provide a New Year's dinner to her starving husband and children, her motive is equally apparent, and from the humanitarian point of view less culpable. Yet the Belgravian lady has been allowed to go away without punishment and without disclosing her identity. The magistrate apparently accepted her counsel's plea of irresponsibility-in other words, that she was a kleptomaniac. As scientific men, we recognise the possibility, and even the probability, of that assumption, but, as logical men, we cannot restrict the plea of mental irresponsibility of that kind to one class of society. If there are rich kleptomaniacs, there must be also poor kleptomaniacs. In reports of police cases it often happens that the motive of an offence is absent or ludi-crously inadequate, but the plea of irresponsible theft on the part of a poor person would be laughed out of court incontinently, while the desire to remain anonymous would be regarded as an aggravation of the original offence in every step of the legal processes to which he would be sub-The plain truth appears to be that criminal iected. law administration has not yet been illumined by the faintest glimmering of the workings of the insane mind. Scientific medicine is perhaps partly to blame, for the minor criminal has been hitherto neglected by alienists, very much as he has been ignored by society. Now and then a wealthy offender who can command counsel is able to deflect the artillery of the police courts. But why should there not be standing experts in all our police courts to protect the unfortunate representatives of what may be described as minor criminal insanity? To complicate the affair still more, the magistrate concerned has since declared the name of the well-to-do kleptomaniac was known to him all the time, although the knowledge does not appear to have been conveyed to the police!

# LEADING ARTICLES.

THE METROPOLITAN HOSPITAL FUNDS AND THE SMALL HOSPITALS.

Were the fate of the small hospitals of London to be dependent on the good-will of the King Edward and the Hospital Sunday Funds, there is little doubt that they would speedily cease to exist. The non-representative constitution of those two bodies prevents any adequate defence of the interests of the lesser institutions. The Hospital Sunday Fund has now abandoned its independency of action in this matter, and has endorsed the policy of the King Edward Fund in witholding grants from all but flourishing and large medical charities. On the other hand the Hospital Saturday Fund continues to support the small institutions with liberal and increasing allocations of money. The key to the

attitude in the last-mentioned case is probably not remotely concerned with the fact that the Saturday Fund is a representative body governed by men drawn from the hospital patient class and from representatives of the smaller medical charities. The Saturday Fund, however, does not limit the qualifications for its franchise to purely democratic lines, for the large institutions are represented as well as the small, and among its principal officers are included men of social prominence who are, as a matter of fact, commonly drawn from the governing bodies of the two other Funds. It is clear, then, that the constitution of the Hospital Saturday Fund is representative of all classes concerned in its administration; in other words, it is under popular or democratic representative control, as distinct from the pure irresponsible autocracy that governs the King Edward Fund. Under these circumstances, it can hardly be without significance that the democratic body, which knows the medical charities from within their walls, supports the small hospitals, which are, with few exceptions, ignored by the Metropolitan Sunday and the King Edward VII. Funds. It may reasonably be asked why the latter bodies should hesitate to have representatives of the small hospitals on their governing bodies. Before the creation of these distributing agencies the small hospitals were supported by the public, whose contributions have been to a very large extent diverted to the Funds, with the result of great and, in some instances, of disastrous loss of income to the smaller institutions. Surely the Funds have a moral responsibility towards the organised charities which they have thus unintentionally damaged. At any rate, we maintain that if in the course of their administrative duties they find that certain institutions, be they great or small, are unworthy of support, then they should say so publicly and give their reasons, so that the public and the institutions thus singled out may know what is complained of, and be afforded an opportunity of putting their house in order. Without representative control and without the right of appeal, the King Edward or any other public administrative body must always be liable to obvious abuses. The principles of the Star Chamber have always been repugnant to the Anglo-Saxon, yet it is difficult to see how they differ materially from that of a Fund which lacks popular representation and control, and which is able to withold public trust money given for a specific purpose from certain institutions entitled to share in that benefaction, without stating the reasons for such a serious and damaging step, without defining its lines of action, and without affording any chance of appeal against its absolutely autocratic actions. Can it be wondered at if in certain quarters the cry is raised at some future time that this or that Fund has been captured in the interests of a class? In France it is said that the Pasteur Institute has attained wealth and influence so great that it practically controls the majority of hospital appointments. Something of the same kind appears to be taking place in London in the case of the two younger Hospital Funds. The recent experience of the Hampstead Hospital appears to show that the Funds are attempting to exercise an undue influence in the matter of hospital appointments. Amalgamation was first of all thrust upon the Hampstead

Hospital in a way that could hardly be evaded. and then the appointments in the consolidated institution were handed over to the consultant class of medical men, who practically alone are represented in the King Edward Fund. There is, of course. nothing to be said against the private character or the professional skill of the gentlemen who accepted those appointments, but the fact remains, or, at any rate, appears to remain, that they are, to all intents and purposes, nominees of the Funds. If that be not the case, we invite a correction, and shall be only too happy to learn from an authoritative source any alternative explanation that may be forthcoming. That the affair is evidently not acceptable to the medical profession as a whole may be inferred from a "warning notice" in the British Medical Journal, which has been regularly inserted ever since the resignation of the general practitioners who originally staffed the Hampstead Hospital. If the Funds attempt in the future to exercise their influence in the matter of hospital appointments they will probably come into collision with the rank and file of the medical profession. Nor is it easy to gather why any such attempt should be made, except, possibly, on the ground that certain interests have gained an undue amount of influence upon autocratic governing boards. The work of the Metropolitan Funds is noble and enduring. It is extensive enough in its legitimate and proper function of the administration of public trust money to engage the whole energies of the philanthropic gentlemen who give their services so freely and unremittingly to its advancement, Above all, our thanks are due to His Majesty the King for having originated so great and useful an undertaking, and to the Prince of Wales for the active personal interest he has shown in its work. At the same time we have felt it our duty to point out what we consider to be defects in the present system, and we give free utterance to these criticisms, in the sure confidence that they will be received in the highest quarters with that breadth of wisdom and of liberal sympathy that has always characterised the relatives of the present dynasty with all classes of its loval and devoted subjects.

# CURRENT TOPICS.

# The Hospital Note System.

At the present time it may be doubted whether any large section of the philanthropic community would be found to favour the system of hospital notes. The best that can be said for that method is that it furnishes an excellent and, sometimes, a much-needed stimulus to charity. It must be a somewhat weak-kneed generosity, however, that needs that sort of patronage by way of recompense, On the other hand, the trouble and inconvenience inflicted upon the poor must be simply incalculable. Take the case of a patient suffering from incipient phthisis, who has applied for admission to a special hospital for the treatment of consumption. No matter whether his case be curable or hopeless. ninety-nine times out of a hundred he has to procure an in-patient letter before his name can be placed on the list. To procure the letter he has to make a round of visits to subscribers, and he may even eventually give up the task as hopeless, especially in view of his state of health. From a

general point of view, it is clear that the more seriously ill the applicant, the less fitted he is to undergo the fatigue and loss of time involved in the search for an in-patient letter. Now that hospital funds have become the intermediaries between the benefactor and the beneficiary, the stimulus of the hospital letter will be less and less applicable-unless, indeed, hospital funds should at any time be forced to augment their incomes in that undesirable way. It would be perfectly logical for the funds to grant letters to subscribers in proportion to the amount of their subscription. It is to be hoped, however, that the day is not far distant when hospital letters will be relegated to the limbo of obsolete machinery, and when the bare facts of being poor and of being sick will be enough to secure instant admission of the worthy to a well-equipped hospital. Were a proper exclusion of well-to-do patients made, there is some reason to believe that our existing voluntary hospital accommodation would be rendered more adequate to the needs of the sick poor.

# Ventilation of Railway Carriages.

It is not surprising that, at this time of year, when the weather is so changeable and travelso frequent, there should be much grumbling about the ventilation and-what is the counterpart of ventilation—the warming of railway carriages. The trouble is specially experienced on the south and short-journey lines, though the longdistant trains are by no means perfect. It is monstrous that, in the year 1909, passengers travelling for two or three hours into the country should have no means of warming a railway carriage except a foot-warmer, and that even that humble attempt at comfort is only to be obtained at a terminus, or through the good offices of an obliging and well-tipped porter. In an Arctic railway carriage we can hardly blame the most air-hungry for shutting all windows as tightly as may be, and warming themselves with the moisture exhaled by their fellow-passengers. In a railway carriage containing, say, eight people, it is highly probable that at least one has, or has recently recovered from, a cold, if nothing worse, and it is still more highly probable that in the bacterial forcing-ground in which he has sat he will have infected two, three, or four of his fellow-passengers. The ventilation of railway carriages in winter depends primarily on adequate heating arrangements, and we cannot think how the public, year after year, allow the railway companies to flout their health and comfort with supercilious disdain.

### Hygienic Corks and Sanitary Bottles.

AMONG the few avenues of death yet unexplored by the enterprising bacteriologist, we learn that the humble cork, which for so many hundred years has stopped the refreshment bottles, is no longer to escape attention. A French medical man, Dr. Bourdas, has sounded the toosin, and war to the knife—or, perhaps, we should say, to the corkscrew—is to be waged. The seemingly harmless cork, it seems, is a rogue of the worst character, because, long before entering its long resting-place in the mouth of the Lottle—indeed, while still attached to its native bark—bacteria have found and fed

upon it. What these bacteria are and what effect they have on human or cork life are not very clear, but nowadays bacteria-by a certain school-must be shot at sight. If it is bad to use new corks, how much worse to use old ones? Dr. Bourdas seems to wonder how anyone can survive the ordeal. When we come to think of it, we are not sure we have not unconsciously lighted upon the cause of the often poor effect of out-patient treatment at the hospitals. Out-patients have to bring their own bottles and corks, and both are old. No amount of healing balm dispensed at the hospital can escape contamination from the cork, and we cannot be surprised if the benefits of the prescription are invalidated. Perhaps the King Edward VII. Fund will appoint a committee to inquire into this important matter.

# A Dublin Branch of the Research Defence Association.

We are glad to learn that a very strong and, so far, very successful effort is being made to establish in Dublin a branch of the Research Defence Association. The Royal Colleges of Physicians and of Surgeons, and the Royal Academy of Medicine in Ireland, have unanimously approved of the formation of such a branch, and, in addition to such purely medical opinion, a very strong body of distinguished laymen have lent their support to the project. Amongst the latter may be mentioned Lord Ashbourne, the Dean of St. Patrick's Cathedral, the Very Rev. William Delaney, S.J., LL.D., Edward Gwynn, F.T.C.D., Lord Iveagh, Professor Joly, F.R.S., the Commander of the Forces in Ireland, Professor Mettam, Lord Monck, Sir John Nutting, the Most Rev. Dr. Peacocke, Archbishop of Dublin, the Earl and Countess of Pembroke, the late Master of the Rolls, Judge Shaw, the Provost of Trinity College, and many others. It is, in our opinion high time that such a branch should be formed, seeing that of the seventeen anti-vivisection societies several have obtained a footing in Dublin and are busily engaged in propagating their doctrines. A striking instance of the harm that can be done when irresponsible people, not overburdened with a sense of the obligation of facts, give their tongues a free run, was mentioned in these columns some few weeks ago. Our readers will remember that just before the annual collection for the Dublin hospitals was made, a lady, at an anti-vivisection meeting, stated that vivisection was performed at almost all the Dublin hospitals, and called on her hearers to refuse subscriptions to them. occurred some couple of months ago, and though the lady has since doubtless learnt that her statements were devoid of even a particle of truth, we are not aware that she has taken any opportunity of correcting or apologising for her statements. It is to combat such people that the branch of the Research Defence Association is to be formed, and we trust that our readers as a body will join it.

# The British Medical Association and its Charter.

The controversy in the British Medical Association arising out of the question of the obtaining of a charter has reached an acute stage, and unless some settlement is speedily arrived at, there is

likelihood of a serious disruption in the Association. There are some indications that the present complicated constitution-inaugurated with such a flourish of trumpets a few years ago-has broken down. In addition, there is considerable difference of opinion as to the true function of the Association. On the one hand, some hold that its work should be mainly scientific, and should centre in the annual meeting as a scientific congress. Others hold that the Association ought to be organised for the defence and promotion of the interests of the profession, due regard being had to local conditions in different parts of the Empire. Between these opposing views it is not easy to find a middle way, and the fact remains that a mass of accumulating wealth remains useless to the profession, both for scientific and political purposes. Again, many members fear that the proposed charter would, if granted, tend to perpetuate the present ineffective working, since it would undoubtedly limit the power of individual members. As we have said, the position is acute, and the combatants show no tendency to come to any agreement.

The New Irish University.

THE troubles of the new Irish University, to which the title "National University of Ireland" has been granted, have begun early in its career, and over a point in itself of trivial importance. The question at issue is the relation of the University curriculum to the Irish language. It is demanded, in somewhat truculent manner, by those who are enthusiastic in the movement for the revival of the Irish tongue, that Irish shall be a compulsory subject in the Arts course, up to the point at which professional specialisation is to be permitted. Some go further, and claim that Irish should be the medium of teaching of other subjects, and that ability to speak Irish should be a necessary qualification for all teaching posts in the University. On the other hand, more cautious persons, including some high academic and ecclesiastical authorities, think that the University would be unduly hampered in its early years if Irish were compulsory. The controversy is being waged with much bitterness in the daily press, and cannot fail to detract attention from really important matters. We trust, however, that the Senate will keep the balance even between contending factions, and will not permit squabbles over details to interfere with their great work of moulding the new University in practical and efficient shape.

### The Cost of Bacteria Beds.

No plan of sewage disposal can be regarded as quite satisfactory unless it furnishes some remunerative bye-product. This ideal has not been attained by modern scientific methods of bacterial treatment, at any rate in the particular means shortly to be adopted at Manchester. The Finance Committee of the Corporation of that city have agreed to the raising of a sum of over £60,000 for the purpose of constructing about ten acres of bacteria beds in one spot, and for the provision of granite to replace clinker almost entirely in twenty-seven acres of second contact beds at another spot. The sewage effluent, thus treated, will be sufficiently purified to satisfy the requirements of the

Mersey and Irwell Joint Committee. The least satisfactory feature of the reports is the terse remark of the Finance Committee to the effect that No income will result from the proposed expenditure." In disposing of the sewage of a great city, it is impossible to lose sight of the fact that a vast potential value is being dealt with, and it is nothing less than a standing reproach to our boasted modern science if all this possible source of wealth is cast into the sea. On the other hand, the community gains by the enhanced purity of the rivers into which the effluent is discharged. It is not a little curious that China, which is certainly not in the forefront of sanitary or any other modern science, restores all the sewage to the soil, and in that way is more conservative of the national wealth.

# PERSONAL.

His Majesty was approached some time ago with a request to open the new pathological department of St. Bartholomew's Hospital, of which he laid the foundation-stone four years ago. The King has now replied that he will endeavour to perform this ceremony about the middle of next month. It is expected that His Majesty will be accompanied by the Queen and Princess Victoria, and considerable ceremony will be observed.

MR. H. H. CLUTTON, F.R.C.S., has been appointed by the King to be Consulting Surgeon to the Osborne Convalescent Hospital for Officers.

PROFESSOR A. R. CUSHNY will open a discussion on "The Action of Alcohol" at a meeting of the Society for the Study of Inebriety on January 12th.

DR. HAROLD R. D. SPITTA, M.D., B.S., D.P.H., has been appointed Bacteriologist to His Majesty's Household.

Dr. F. R. MUTCH, for many years Chairman of the Health Committee of Nottingham, on recently resigning that post, was congratulated on his success in the office by special resolution of the Nottingham Medico-Chirurgical Society.

PROFESSOR VON KORANYI, who has recently retired from practice, has been created by the Hungarian Government an hereditary baron, a distinction which has never befallen a medical man in that country before.

In the Church of St. John the Evangelist there has just been placed a memorial brass to the late President of the Royal College of Physicians of Edinburgh inscribed:—"In loving memory of Charles E. Underhill, M.B., P.R.C.P.E., born March 8th, 1845, departed this life April 24th, 1908."

THE New Year's Honours are confined, as is usual at this period, to the Indian Services, in which we are glad to notice the name of Surgeon-General Bompard, M.D., Director-General of the Indian Medical Service, who becomes a Knight Commander of the Indian Empire.

THE Kaisar-i-Hind Medal for public service in India to Mrs. Surojini Naidu, wife of Surgeon-Capt. M. G. Naidu, Principal Medical Officer, Golconda Brigade, and to Capt. Eugene J. O'Meara, Civil Surgeon of Mizapur.

# A CLINICAL LECTURE

ON

# HÆMOPTYSIS AND EMPHYSEMA.

By LEONARD WILLIAMS, M.D., M.R.C.P.,

Assistant Physician to the Metropolitan Hospital; Physician to the French Hospital in London,

THERE are a great number of people going about who are supposed to be tuberculous, but who are, in point of fact, no more suffering from tubercle than they are suffering from elephantiasis. This woman is a case in point. Her age is 53, an age at which, I admit, tubercle is rather apt to lay hold of those who have a predisposition in that direction. It is the age of decrescence, the "gloaming of life," as the French artistically put it ("age crépusculaire), and it is when the vital forces begin to decline that the powers of resistance against tubercle become depressed.

This patient has been going about with a diagnosis of tubercle upon her for some twelve months, and yet she does not look tuberculous. She is not only well mourished, she is even stout. So far from being anæmic, she is florid. She makes no complaints of night-sweats, and has no tuberculous family history. But she coughs, and not only so, but she has had two or three attacks of hæmoptysis, and it was apparently on this combination that the diagnosis of tubercle was based. Now, it is scarcely necessary for me to insist that hæmoptysis is by no means necessarily tuberculous. The accident owns many causes, amongst them, and one of the commonest, being mitral stenosis. A person with mitral stenosis may very easily have a chronic bronchitis from back pressure on the lungs, so that, to the attacks of hæmoptysis, there is superadded a chronic and distressing cough. Hæmoptysis, even when accompanied by a cough, is therefore by no means necessarily due to tubercle. Another cause of hæmoptysis is high bloodpressure, the blood in this case issuing not from the pulmonary, but from the bronchial vessels, which are branches of the thoracic aorta; and, as you know, a person with high blood-pressure may bleed from anywhere. He may bleed from his bronchial vessels, he may bleed from his nose, from his gastric mucosa, from his kidneys, and even into his retina. But the patient before us has not got any lesion at her mitral valve, nor is her blood-pressure (150 mm. Hg.) sufficiently high to lead us to attach the responsibility for her hæmoptysis upon her bronchial arteries. When you come to examine her you will find that she has an enlarged liver, and you might be led to suppose therefrom that this was a case of hepatic cirrhosis. In the out-patient room people are not very accurate in their statements, and they frequently say that they have coughed up blood when they have vomited it, and vice versa. I think, on the whole, that they prefer to say that they have vomited it, because the vomiting of blood seems to them to be a more heroic proceeding than the mere coughing of it up. However that may be, it is often very difficult to be sure from the patient's description alone whether the blood has issued from the stomach or from the lungs. In this case, happily no ambiguity is possible, for she has been seen by an intelligent observer to cough up three or four teaspoonsful at a time. The enlarged liver, therefore, is evidently not the cause of the hæmor-thage. A little careful questioning of this patient will show that she has been troubled with a cough for several years, that the cough is always worse in winter and better in summer, and that it is of a wheezy, breathless type, very different from the dry, hacking, spasmodic effort which characterises tubercle. An examination of her chest shows that she has, in effect, a very decided degree of emphysema. You will hear all over the upper part of the chest the high-pitched inspiration and the prolonged low-pitched expiration which is so characteristic of the condition. The normal areas of dulness are very difficult to elicit. If you trusted to percussion alone you would imagine that the heart had shrunk to the size of a shilling. The upper border of the liver is impossible to make out; all over both bases behind are the moist, wheezy râles of a chronic bronchitis.

Now what is the relationship between a condition of this kind, which is all too common in out-patient practice and hæmoptysis? If you will consider the pathology of the disease you will, I think, agree that we ought in reality to feel surprised that hæmoptysis does not more often occur. In emphysema the aircells run into one another by the breaking down of their partitions, and in these partitions there are blood-vessels. When this breaking-down occurs, therefore, it ought not to surprise us to find that a rupture of the vessel ensues. And not only so, but when emphysema has been in operation for some years, the amount of room in the lungs in which the blood may circulate is seriously diminished, so that the capillaries which remain are liable to be much overcharged with blood. When we consider their delicate texture it is surely only to be expected that they should occasionally rupture and give rise to hæmoptysis. Emphysema, in fact, especially when complicated with bronchitis, offers the same difficulty to the return of the systemic venous blood as is offered by mitral stenosis. The difference is one of degree only. The block in the one case, it is true, is at the mitral valve; in the other case it is just in front of the pulmonary valve. The difficulty which the right ventricle encounters in getting the blood out of its cavity into the pulmonary capillaries is very much the same as the difficulty encountered by the auricle in getting the blood out of its cavity into the left ventricle. The results in both cases are more or less the same—namely, the production of a back pressure. In the case of mitral stenosis the back pressure shows itself primarily in the lungs, secondarily in the liver, and finally by the ædema of the lower limbs. In the case of emphysema it is the right ventricle which shows the first signs of trouble, and, in order to overcome that trouble, it hypertrophies. The blood which cannot be forced through into the lungs is passed back into the liver, which then acts as a reservoir for the superfluous fluid, and the train of events with which we are familiar in mitral stenosis then becomes repeated—the œdema of the lower limbs and the

ascites.

Now, this being the state of matters, one is led to inquire how it is that hæmoptysis does not more often occur in emphysema. We know that there is a great destruction to the pulmonary capillaries, and we know also that the right ventricle tries to force the unoxygenated blood into the area where it may expect to meet with the vivifying oxygen. The remaining capillaries very soon become stretched, engorged and degenerated, so that here, if anywhere, is a condition eminently favourable to a hæmorrhage. Why does that hæmorrhage not more often occur? Well, the explanation was long ago supplied by Rindfleisch, who showed that wide communications are formed between the pulmonary artery and the pulmonary and bronchial veins, thus relieving the tension in the former vessel and allowing the blood to pass through the lungs without undergoing proper aeration. This want of proper aeration is, of course, the reason of so much distress amongst those who suffer from this disease, and when they live in a climate like our own, more especially in large towns, where at best there is a deficiency of oxygen, and where they are subjected to additional difficulties imposed by fogs, the results of this defiCLINICAL LECTURE.

cient aeration become extreme; the lungs are irritated by their futile attempts to obtain the necessary vapour, and a state of chronic inflammation ensues.

Now, it seems to me that what is to be learned from a case of this kind is, in the first place, to beware of making a diagnosis of tubercle except on sufficient grounds. Hæmoptysis alone does not afford such grounds. With very little care one ought to be able to come to a conclusion as to the cause of an hæmoptysis within a day or two of its occurrence. One of the best means of helping us to a conclusion is the use of the hæmomanometer. In the case of an hæmoptysis where the blood-pressure is low, one certainly has good ground for grave suspicion. The bacillus of tubercle is a vaso-dilator; a tuberculous person almost invariably has a subnormal blood-pressure. Where, on the other hand, the blood-pressure is high, one may always assume that the blood has issued not from the pulmonary, but from the bronchial vessels—that, in fact, the hæmorrhage is due to what Sir Clifford Allbutt calls hyperpieses, to high arterial tension, and not necessarily to any organic disease. Where the blood-pressure is at, or about, the normal level, one may be in the presence either of emphysema or of mitral stenosis. It rather depends upon the stage of either of these diseases what the blood-pressure will be. In not very advanced cases the blood-pressure may be low; in very advanced cases it may be high. But in a general way it is not conspicuously one or the other.

In our endeavours to exclude tubercle as a possible cause, we ought never to neglect the simple expedient of examining the sputa for the bacillus. I need not remind you that a negative result must not be regarded as conclusive; that it is necessary to repeat the examination two or three times; whereas from a positive result there is no appeal. But even where no positive result is obtained, there are other means of coming a conclusion about the existence of commencing tuberculosis. These are two numerous to recount at present, but I have elsewhere (a) considered them in

some detail.

The mistake in diagnosis from which this woman has been suffering has resulted in a considerable aggravation of her difficulties. She has been fed on stimulating foods, and has been given stimulating and tonic medicines. This is, of course, the very reverse of what should have been done for her. Having regard to the fact that she has had more than one attack of hæmoptysis, it looks as if the communications described by Rindfleisch as being generally formed between the pulmonary artery and the pulmonary and bronchial veins, have not been formed in her case, so that the back pressure is obliged to relieve itself by these hæmorrhages. Obviously, therefore, the first thing to do, if you can get your patient to consent, is to perform venæsection. If she will not consent (and not many of them will), you must have recourse to other forms of depletion: mercurial and saline cathartics freely administered and often repeated; a diet which is unattractive and unstimulating must also be insisted upon, for a time, at any rate; and, if it can be managed, she should be removed to some locality where the climate is more equable and the air is purer than it is in the north-east of London.

So far as drugs are concerned, there is not to my mind anything which can compare with the iodide of potassium. This, when combined with a little camphor and a little ammonia in an infusion of senega, acts more helpfully than anything else. There is in this case, of course, another factor which we cannot altogether leave out of account, and that is her age. She is at, or about, the change of life, and we must be careful in giving her medicaments and in prescribing for her regimes, that we do nothing to intensify the difficulties incidental upon that period. Fortunately, everything that I have suggested the present time is not in any degree contra-indicated by such a consideration. They are, indeed, all measures which are proper to the treatment of the menopause. If, however, any difficulties did arise, either as complications or otherwise—difficulties, I mean, of the functional neurotic type—the addition

of some bromide of potassium to her medicine would in all probability speedily dispel them. There is another drug of which I have not yet had sufficient experience to speak with confidence, but of which I may say that it seems to offer considerable advantages, and that is valerianite of menthol. But of all the drugs which are useful at this time, probably none is more efficacious than a really active preparation of ovarian extract.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor E. Rimbaud, M.D., Director of the Clinique at the Faculty of Montpellier. Subject: Pneumonia in the Aged."

# CLINICAL LECTURES FOR 1909.

WE have been favoured by promises of Clinical Lectures from the following Hospital Teachers and Post-Graduate Lecturers, to whom we tender our best thanks :-

WM. ALEXANDER, M.D., R.U.I., F.R.C.S., Lecturer on Clinical Medicine, University of Liverpool.

HY. R. ANDREWS, M.D.Lond, M.R.C.P., Assistant Obstet. Physician, London Hospital; Teather of Practical Midwifery, London Hospital Medical School.

Medical School.

A. W. Baker, M.D., B.Ch., F.R.C.S.I., Consulting Dentist, Royal Victoria Eye and Ear Hospital; Dentist, Incorporated Dental Hospital, Ireland.

Sir James Barr. M.D., F.R.C.P.Lond., Physician, Royal Infirmary,

Liverpool.

H. Bennon, M.B., F.R.C.S.I., Surgeon, Royal Victoria Eye and Ear Hospital, Ophthalmic and Aural Surgeon, Royal City of Dublin Hospital.

Hospital.

James Berry, M.B., B.S.Lond., F.R.C.S., Senior Surgeon and Lecturer on Clinical Surgery, Royal Free Hospital.

W. Langdon Brown, M.D.Cantab., M.R.C.P.Lond., Medical Registrar, St. Bartholomew's Hospital, Physician to the Metropolitan Hospital. Harry Campbell, M.D.Lond., F.R.C.P.Lond., Physician to the North-West London Hospital and to the West End Hospital for

North-West London Hospital and to the West End Rospital Services of Surgery in King's College Hospital, Professor of Surgery in King's College. Hospital, Professor of Surgery in King's College. EDMUND CAUTLEY, M.D.Cantab., F.R.C.P.Lond., Physician to the Belgrave Hospitals for Children and to the Metropolitan Hospital. PROF. H. CHAUFFARD, M.D., Physician to the Paris Hospitals. George L. Chiene, M.B.Ed., F.R.C.S., Assistant Surgeon, Royal Infirmary, Edinburgh, Senior Demonstrator of Surgery, University of Edinburgh.

J. Jackson Clarke, M.B.Lond., F.R.C.S., Surgeon to the Royal National Orthopædic Hospital and to the North-West London Hospital.

National Orthopædic Hospital and to the North-West London Hospital.

W. BRUCE CLARKE, M.B.Oxon., F.R.C.S., Surgeon to, and Lecturer on Surgery, St. Bartholomew's Hospital; Examiner in Surgery, Oxford University.

EDRED M. CORNER, B.Sc.Lond., F.R.C.S., Surgeon in Charge of Outpatients, St. Thomas's Hospital, Senior Assistant Surgeon to the Hospital for Sick Children.

M. F. Cox, M.D.R.U.I. (Hon. Causa), F.R.C.P.I., Physician, St. Vincent's Hospital, Dublin; Consulting Physician, National Hospital for Consumption, and Children's Hospital, Dublin.

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Royal Infirmary, Edinburgh; Professor of Midwifery, University of Edinburgh.

Deboye, M.D., Doyen de l'Académie de Medécine, Paris, Physician to the Beaujon Hospital.

M. Dempsey, M.D., F.R.C.P.I., Visiting Physician, Mater Miscricordiæ Hospital, Dublin.

PROY. A. DIETRICH, M.D., Prosector at the West-end Krankenhause, Charlottenburg, Berlin.

J. O'Conor Donelan, M.D., Medical Superintendent of the Richmond District Asylum.

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Jakob Ernheim, M.D., Professor of Clinical Medicine, University of Vienna.

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<sup>(</sup>a) "Minor Maladies." Second Edition. 1908. Page 33.

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# ORIGINAL PAPERS.

# THE OUESTION OF DEMENTIA PRÆCOX.

BY ROBERT JONES, M.D.LOND., F.R.C.P.LOND.

In any province of experience the systematic arrangement of the facts pertaining to it is regarded as one of the most useful instruments in its comprehension and understanding, and for this reason a systematic classification of the various forms of in-sanity has long been accepted as one of the best signs

of psychiatric progress.

The saving of repetition, the avoidance of endless and useless enumeration of single cases, the time saved by their arrangement into kinds or groups, and the assistance to diagnosis, prognosis and treatment, have always justified attempts at a classification of the insanities. So unsatisfactory has every scheme hitherto presented proved itself to be, that it was no new thing to hear murmurs of disapproval with the table presented by a special Statistical Committee of this Association at the annual meeting two years ago. Yet so necessary and helpful is a proper scheme that it at once strikes the merest tyro, and we know that the first self-imposed duty which a fresh medical officer in an asylum performs—and this with the gratification and the excitement of a new discovery—is to invent and evolve a classification of his own, dividing the various forms into groups or kinds into which, in his opinion, any case can with ease find a ready place and label.

It was upon a motion proposed by our President, Dr. Mercier, in 1905, that a committee was appointed to draw up a "Table of Disease," and to report thereon to the Association. In their final summary presented by Dr. Percy Smith are these words:—"In the existing Table 'Stupor and States of Confusion' and 'Primary Dementia' are found, and the committee consider that they are of sufficient clinical importance to justify separate headings, as is recommended. The question of 'Dementia Præcox' was, of course, carefully considered, and the committee did not desire to re-insert this term." The latter statement has undoubtedly been a disappointment to some who appreciate and follow the teachings of Kraepelin, and this special title has certainly received the adherence of many of the younger authors and writers, more particularly in America and in Germany.

It is no easy matter to divide pathological mental states into groups characterised by the possession cf such common characters and marks, that upon a survey any occurring case of insanity can with confidence be therein included. The conjunction of characters that agree and the separation of those which differ do not enable us to classify with facility and confidence diseased forms of every mental constituent, and much care requires to be exercised to use terms exactly and definitely. There is no unanimity even in regard to the classification of the normal mind, for Sir William Hamilton taught that mind could be analysed into three main fundamental constituents, and he considered cognition or thought, feeling, and will or conation to be elemental faculties of the mind, and in Bucknill and Tuke's Insanity, p. 41, edition 1874, a classification of the insanities appears based upon this analysis. It would be correct to state that since the time of Aristotle, who recognised only two main divisions of mind-viz., intellection and conation—until to-day, when there is again a tendency to revert to almost the same dual division, ultimate mental constituents remain a matter of speculation and discussion, and it is not surprising, therefore, that a classification of morbid mental features as observed in insanity should meet with a similar fate.

It is not my object to-day to review the whole systematic arrangement presented in a classification of the insanities, but to deal with one division only, and I would point out that although Esquirol described the so-called dementia præcox under the term quired imbecility," it was not until twenty years or so ago that an attempt was made to group together several more or less allied forms of insanity in the adolescent under the same heading, but under a new name.

I doubt if a more expressive term could be found for this group than was used by Esquirol under "acquired imbecility." It singles out what appears to satisfy the needs of a perfect definition, and supplies the whole connotation of the term. Morel, in France, and Christian also, in his description of "juvenile dementia," anticipated this grouping, which has been further dealt with by Sérieux, but to Kraepelin belongs the distinction of inventing dementia præcox, not as the discovery of a new disease, as some of his disciples urge, but as the grouping together of symptoms which are characterised in the main by progressive deterioration. Whether this grouping is a justifiable one it is the object of this discussion to elicit. It may be observed that the term "dementia præcox" receives no mention in Tuke's Dictionary of Psychological Medicine, and neither Dr. Clouston nor Dr. Savage mention it in their earlier works; moreover, it does not appear in the index to Dr. Bevan Lewis's text-book, yet no one who has read these manuals will deny that all the symptoms descriptive of this condition were not fully realised, accepted and described.

Let us consider for a moment the meaning attributed to the word "dementia," and, so far as I understand the term, it connotes, in the first place, an un-emotional state, for there is neither excitement nor depression, only pronounced inactivity; it is characterised by a negative manifestation of brain action as contrasted with any positive symptoms of excitement. In the second place the term pre-supposes a full development of the mental powers. It is contrasted with amentia, which implies a congenital state, and it is accepted as describing a form of mental disorder characterised by acquired, as compared with congenital enfeeblement of the mental powers. It is not easy to fix any parof the mental powers. It is not easy to fix any par-ticular degree of mental impairment or inactivity as definitely fixing or constituting dementia, but use and custom associate the degree of loss with a depth from which there is usually no recovery, and if there be any one symptom which with confidence can be taken and relied upon as characteristic of dementia, it is loss of memory.

The qualifying "præcox" merely signifies ripe, untimely, before its time; but it has in this particular, as will be seen later, a somewhat extensive application.

In the short printed abstract of what I had intended to say, I made, somewhat didactically, but "with malice aforethought," the statement that stupor was the most prominent symptom, and also that there was a feeling tone of depression in these cases, a condition which was accepted under the very apt definition of melancholia cum stupore.

The presence of stupor is in agreement with the principle laid down by Kraepelin when he added katatonia to the group of general insanities in young people first described by Hecker under the title of hebephrenia, an insanity which he described as beginning ning at the age of puberty, but which has of late received further extension of time from puberty through adolescence and into maturity, and ending in general intellectual enfeeblement. Kraepelin further added a variety of mental aberration characterised by unsystematised and varying delusions described as paranoid insanity. To this class or group the term "dementia præcox" was applied. Kraepelin did no more than group together these three varieties, but many of his pupils allege that he created a new entity, and has thus described what some believe to be a new

It may be well to consider more fully the varieties included under this heading, and firstly hebephrenia, which Kraepelin describes as commencing with hallucinations and delusions, but these tend to disappear; there is jerky mannerism and eccentricity, there is loss of voluntary attention and activity, loss of interest, and apathy, ending, it may be, in speechlessness or "mutism." The cases in this category include those with maniacal excitement, followed by depression, and ending in permanent mental enfeeblement, although it is stated that about 8 per cent. of dementia præcox of this variety recover.

Katatonia (κατα τέινω—to stretch or strain oneself) is applied to a form of insanity characterised by

hallucinations as well as by apathy, loss of interest and of attention, merging into a state of stupor with muscular tension. There is also what is described as "negativism"—refusing to speak, or "mutism," being the best example of this; and here I would venture to ask for a definition of this term. Does "negativism" describe the patient's state to the examiner, or does the term apply to the patient's own mental state and imply loss of consciousness? If the latter, then I would prefer to describe the patient's mental condition as "positivism" rather than "negativism." Cases of this kind are often most resistive, and refuse to do negativism "-refusing to speak, or "mutism," being of this kind are often most resistive, and refuse to do anything requested of them. In addition, there is a anything requested of them. In addition, there is a state of increased susceptibility to suggestion, and such opposite conditions as "negativism" and "suggestibility" pass from one into the other directly, or after impulsive excitement, and thus is seen what is termed "stereotypy," or "stereotyped movements," which are actions repeated purposeiessly and sense-lessly. Although to per cent of these cases recover. lessly. Although 13 per cent. of these cases recover, yet there are no means to judge which cases will recover, or which may lead to different degrees of deterioration.

The third variety, paranoid forms ( $\pi a \rho a \nu \cos - dis$ traught, frenzied) are described as resembling those of chronic delusional insanity, only that the delusions develop more rapidly, and they are less systematised. Hallucinations and delusions of either or both persecution and grandeur occur, and these are believed to be more persistent than in the hebephrenic and katatonic varieties, but they also tend—though less to pass off as mental deterioration progresses. There may be in this variety some katatonic stupor, the pararoid patient being also subject to apathy, loss of interest and activity, and the same "mannerisms" of katatonic patients and the same "stereotypy" are also observed.

It must be acknowledged that there is no hard and fast line to indicate any one of the above groups; the symptoms overlap, and they are interchangeable—for the symptoms of the one are not infrequently observed in the other; indeed, it may be stated that many of

the symptoms are common to all three forms.

Such a classification, with the symptoms of each variety overlapping, fails in one of the fundamental necessities of a logical division, for the varieties are not mutually exclusive. Such an absurd classification would resemble a division of the army into infantry and commissioned officers rather than into cavalry, infantry and artillery.

Can anyone, with experience of the above, and who has a knowledge of practical insanity, for one moment consider these closely-allied varieties to be different kinds or forms of insanity, or that they are limited to adolescence? If this be the case, then it is impossible to include any one class of dementia præcox as "a form of insanity at any one time," such as at the time of observation or of noting, although there are some who propose to diagnose these varieties by so simple an action as a "shake of the hands." If the above classification be a typical one, then I can only say that in Claybury Asylum, with nearly 2,500 patients, there are not more than 5 per 1,000 cases of dementia præcox among the total population; whereas Kraepelin, I believe, considers that the vast majority of the residents in institutions for the insane are cases of this form.

It is not surprising that there is a difficulty in fixing definite types of insanity during the period of youth, for it is one of extreme complexity and variety. The gradual unfolding of the sexual function is accompanied pari passu with an expansion of the emotional life, and during the special epoch of life the mind becomes charged with latent changes, which on the emotional side may well be described as dreamy

longings and per-fervid passions.

During this period, as Dr. Clouston says, intelligence is nascent, ideas are inchoate, and the whole mind is lacking in precision and conscious power. The period of puberty-from 12 or 13 to 15 or 16 years of age—has its special mental formula, and so has the period of adolescence. In both the mental states are different from that in maturity. There is a difference not only of degree, but also of kind, between the several stages of youth and those of manhood, or womanhood, or maturity; and the same causes, or set back, or disturbances give rise, in precisely the same effects, to the same dementia. It is the same shedding of the last acquired and least organised attainment, and the injury to the mind is the same in youth as in subsequent periods of life, the only difference being in its manifestation. In the one period the delusion is tinted with the hopes, the ideals, or the tender sentiments of youth, whereas in adult life it is the result of mature experience.

Pulmonary tuberculosis in the adult lunatic is precisely the same disease as in the stuporose adolescent, although there has been no cough and no expectoration in the latter. Dementia is the same injury in both, only with different manifestations, depending upon the period of life which has its special mental state. Acute rheumatism in adults affects particularly the joints, but in youth the endocardium and the bloodvessels, yet no one considers these to be different diseases requiring a special nomenclature. Ostewarthritis in adults affects the joints generally, yet when it occurs in the young, one joint alone is seen to be affected; still it is precisely the same disease. In just the same way dementia is the same whether affecting young or old, and it needs no special nomenclature.

The grandeur, the false ambition, the mannerisms, and the neologisms of the adolescent lunatic have their roots in the romance, the poetry, and possibly the artistic sensibility of normal adolescence; whilst the ambitions of the adult mono-maniac are the result of his maturity, his past experience, and the effects of his competition for a place in the struggle for existence. The delusions affect the environment as well as the personality of the individual, and he is persecuted, jeered at, or admired as external or internal associations predominate.

The delusions of the hebephrenic or of the paranoid are exactly of the same mechanism as occur in adult life, and Dr. J. S. Bolton has aptly illustrated this by his theory of the inherent neuronic durability, which admits the same injury at varying periods and depending upon the special neuronic resistance. Kraepelin himself accepts this to some degree when he extends the period of this dementia to middle age.

The fact that in adolescence there is great fluctuation of feelings and sentiments accounts for the fantastic delusions on one hand and the languor or stuporose depression on the other. Even in health periods of enthusiastic energy give place to dissatisfaction and introspection; in youth this is especially characteristic. But is there a real difference between the apathy and stupor of katatonia and that observed after any great mental disturbance, such as that seen in the adult after acute attacks of mania, melancholia, folie circulaire, epilepsy, or even general paralysis and other forms of dementia? Indeed, the tendency today is to regard all suspension of psychical operations and all stupors in which the mental processes are more or less in abeyance as coming under the term "katatonia" and being closely allied. I believe that the varieties of what are described as dementia præcox are closely allied, if not identical with what occurs in primary dementia at any period of life, the only difference being due to the different stage of evolution at which the dementia occurs, and at the onset I venture to deny the very existence of such a special form of mental disorder as "dementia præcox."

"There is no new thing under the sun," was observed by Solomon in "Ecclesiastes," but he was probably not so well versed in insanity as his father David, and if his wisdom were appealed to to-day it would draw attention to the neologisms of the modern alienist.

Take, for example, hebephrenia! I wish to know what is the relationship between Hebe, the daughter of Juno and the wife of Hercules, with insanity? Why should this goddess be associated with mental deterioration and decay? Again, in my dictionary, "stereotypy" is stated to be the art of casting by means of a mould, and in another place the art of making stereotype plates!

The term "negativism" does not exist either, but "negativeness" does appear, and is the quality of being negative, a negative being further described as a "picture on glass in which the light parts of the

original are opaque and the dark semi-transparent!" There is no connection suggested between these terms and insanity, although they appear to be the stockin-trade of the alienist of to-day, and I cannot but deplore the coinage of new terms when our own language is so rich in descriptive application.

It would appear from this account of dementia præcox, with its teeming multitude of new names—echopraxia, intra-psychic ataxia, echolalia, psychoanæsthesia, heboid insanity—that such a group of mental disorders never existed before; but what about the condition described by Esquirol as "acute dementia," by Hayes Newington as "anergic stupor," and by another as "apathetic stupor," in cases where the patient is deprived of all manifestations of mental as well as of motor energy? The older classification of "mental stupor" gave the hope of recovery which does and did occur, but the term "dementia" conveys the idea of mental degeneration and irrecovery; yet, as stated, recovery not infrequently occurs. Regarding this point Dr. Clouston states:—"Kraepelin has taken the term 'dementia præcox' and applied it to practically the whole group of my adolescent cases as described by me in 1873, making it cover the curable and incurable. I object strenuously to the word 'dementia' as applied to any recent and curable varieties of mental disease as being confusing and unscientific."

I confess that many cases of mental stupor demonstrate upon careful examination the existence of delusions, and the term "dementia" is hardly applicable to them. I have such a case recently within my memory (photographs exhibited). A man, æt. 25, was admitted under my care with marked stupor and rigidity. He had general anæsthesia, for even deep pin-pricks elicited no response, and yet he felt them, but could not speak or flinch from them owing to the paralysing influence of a great dread. He was mute, cataleptic, and yet he retained full consciousness, for upon emerging from this state his mind was clear, and he repeated every occurrence which he heard around him; conversation was repeated in minute detail, but he was so overpowered with imaginary dread and he was so apprehensive of harm that he could utter no sound at the time. I prefer to call such a case by the old descriptive term "melancholia with stupor," or "melancholia attonita." Another case of melancholia with stupor occurred in the case of a female, æt. 45, and it was typical of the cataleptic variety. I think in neither could the term "dementia præcox" in the other it was not precocious nor untimely. My personal feeling is that for cases up to 45 or 50 this term is too wide in its range, and therefore it is improper to call such cases those of dementia præcox.

term is too wide in its range, and therefore it is improper to call such cases those of dementia præcox. I cannot appreciate the term "para-noid." Why not manoid, melancholoid, paraloid, if the one coinage be justified? I have the same feeling in regard to pseudo-general paralysis. A thing is either what it is or it is not, and such a form of disease is either general paralysis or it is not. A mental state is either paranoia—and Dr. Percy Smith has settled this matter

Again, the characteristic feature of dementia is, as I have already said, loss of memory. The mental reflexes are blunted and inactive, and all interest in former concerns are ended, yet the so-called cases of dementia præcox are most retentive in their memories. After years of asylum residence they can relate with wonderful accuracy what has taken place in their daily lives, and this although they appear to take no pleasure in the society of their kindred, the patient standing about in a state of passive indifference to all environment.

ence to all environment.

Although I animadvert upon Kraepelin's terminology, I am not here to suggest a new scheme of classification, but to criticise the present, and to elicit the opinion of others whose experience and observation of all forms of mental disorders exceed my own. Some who have written upon the subject are delighted that Kraepelin has invented dementia præcox, for they say he has thereby encouraged the alienist to make a diagnosis at once, and not "postpone prophecy until after the event," which nevertheless the use of this term demands.

A terminology which suggests the ultimate termination of a disorder is in my opinion somewhat premature and inapplicable at its inception, more especially if, as in these cases, there is occasional recovery. In an interesting paper by Dr. Drapes (Journal of Mental Science, 1906) upon the unity of all insanity, there are very cogent reasons presented for the exclusion of demential precor and L believe the same view. sion of dementia præcox, and I believe the same view is entertained by Dr. Mercier in a paper printed in the Journal of Mental Science, January, 1905. A further paper by Dr. McConaghey (Journal of Mental Science, April, 1905) proposes the sub-division of adolescent insanity to represent the varieties covered by dementia præcox, a view which has long been adopted dementia præcox, a view which has long been adopted by Dr. Clouston, who gives valuable statistical experience upon the subject. In my experience for the last five years at Claybury, 2,879 young men and women between the ages of 10 and 25 have been received, a slight majority of these being females, and recoveries occurred in 36 per cent. Clearly, therefore, the term "dementia" is out of place. I have included in this group all cases of mania and melancholia, for Kraebelin appears to embrace all forms of insanity of pelin appears to embrace all forms of insanity of adolescence in his group, yet all know the grave prognosis there is in certain stuporose cases, which some of us still term "primary dementia," and which Dr. Savage has so very epigrammatically included in his maxim that it is often \* better to be sixty than sixteen" in regard to the termination of such cases of insanity.

I have been frequently struck by the association and relationship existing between motor and psychic states, and I have witnessed a kind of mental chorea accompanying certain impulsive, motor states. It may not be unlikely that there exists a physiological relation-ship between mental stupor and certain forms of motor spasm or rigidity, just as there is an association between certain muscular paralysis and the mental symptoms of general paralysis, but hitherto it cannot be said that this form of mental enfeeblement in adobe said that this form of mental emechanisms lescence has been illuminated by any definite pathology, and up to the present the researches of Drs. F. W. Mott and J. S. Bolton have approached the subject with the most light.

I cannot conclude without expressing obligations to Dr. Johnstone, of Leeds, who by his excellent and clear translation has brought the valuable researches of Kraepelin within reach of the ordinary student.

Summarising my conclusions:—
(1) There is no definite disease "dementia præcox." The descriptions applied cover almost every possible variety of insanity.

(2) The term "dementia" is inapplicable, because it connotes permanent and irrecoverable loss of mental function.

(3) The application of "dementia" is unsatisfactory to cases in which loss of memory is not a prominent early symptom.

(4) The term does not state whether it is the terminal stage or the stuporose condition which is of primary importance.

(5) The qualifying adjective "præcox" is equivocal, in so far as it leaves it doutbful whether the diseased condition evolves precociously, or whether it is stated to occur in early life or youth. It is therefore a vague and indefinite term, as these symptoms are also known at maturity and even at the menopause, and therefore they should find no place in a scientific or logical classification.

(6) A term which implies a definite entity, and which is with some becoming more accepted as such, should be distinguished by definite pathological findings, which is not the case.

(7) Finally, it is more in harmony with practice and of greater help to diagnosis and treatment, to use, in place of "dementia præcox," the term "adolescent insanity," suitably sub-divided as at present.

DR. HENRY, who is retiring from the position of Medical Officer of Health at Rochdale, has been the recipient of several valuable presentations. He has held the position for 29 years, and will be succeeded by Dr. Anderson, of Aberdeen.

### INTERMENSTRUAL PAIN. (a)

By R. D. PUREFOY, M.D., F.R.C.S.I., Late Master of the Rotunda Hospital.

ONE of the least common and least understood varieties of pain connected with, and dependent on, ovarian functions is that to which Priestley, in 1872, applied the term "intermenstrual." Medical literature does not abound in records of cases in which this pain has been observed; and even in the records furnished us, details are but sparsely given, both as to treatment and its results. In my experience the affection has proved generally rebellious to treatment, and very liable to recurrence. Observers are pretty well agreed that it is an affection of late, rather than of early years, probably most frequently met with between the ages of twenty-five and thirty-five. Its relation to childbearing deserves notice. Those who suffer from it are in most instances sterile, or if mothers have not been pregnant for several years. In some of my cases it occurred for the first time after the conclusion of a pregnancy; in none was it experienced during the very early years of menstrual life.

The majority of those who suffer in this way describe the attack as beginning at a point of time midway between two menstruations; but I have noticed that in a proportion of cases it begins ten, or seven days before menstruation. Relief is generally coincident with the establishment of the menstrual flow; and entire cessation of the pain generally ensues for a variable period. In some instances an observable discharge, either uterine or vaginal, synchronises with the pain; two of my cases illustrate this fact.

Menstruation in these cases does not follow any invariable type, and is sometimes normal in amount; but, in my observation, more generally either scanty or profuse, and attended with pain.

A very interesting question remains—viz., with what lesions of the ovaries or other organs is this affection most frequently associated? On this, as on so many other points connected with our subject, we are compelled to speak somewhat vaguely, as, neither from our own experience nor from that of others, has it been found possible to draw reliable conclusions. I have found it associated with (1) healthy uterus and appendages; (2) endometritis; (3) subinvolution; (4) retroversion. We may at this point advantageously contrast some of the many opinions expressed by others on the subject of this communication. Lawson Tait alludes to this affection thus: - "Since reading Dr. Priestley's paper, I have seen several cases, but have been unable to refer them to any category." In Bland Sutton and Giles' "Gynæcology" we read: -- "Causation and pathology of this affection are as yet obscure; it has been attributed to recurring painful ovulation, independent of menstruation. The more probable explanation is, that it is due to painful efforts on the part of a diseased tube to expel its contents. In the majority of instances it has been found associated with tubal mischief, and especially with that curious condition known as intermittent hydrosalpinx. It is suggested that the uterine congestion which precedes menstruation causes occlusion of the uterine ostium and accumulation of catarrhal contents in the tube; the distension causes pain. When menstruation occurs the congestion is relieved and the uterine ostium of the tube becomes patent, and the tube discharges its contents. Pain is then relieved.'

The authors may claim some credit for their ingenuity in elaborating such a theory; but it is not in accord with clinical facts, though, as we shall

<sup>(</sup>a) Read before the Royal Academy of Medicine in Ireland.

see a little later, Dr. Martin seems inclined to accept this view. When writing of ovarian dysmenorrhæa. the late Dr. Thomas observes :- "One very curious phenomenon which now and then marks these cases is the occurrence of intermenstrual pain. At times this occurs with wonderful regularity on a certain day. In one case in my experience it occurred on the ninth day after menstruation had ceased, in another on the fourteenth, and in a third it com-menced one week after the menstrual act and continued for five or six days." Fehling explains intermenstrual pain as a normal ovulation between two menstrual periods, On this point Macnaughton-Jones remarks: - "How common such pain is every gynæcologist is aware, and the relief of this symptom as well as the pain of ordinary menstruation by treatment of the ovaries, or their massage, is explained by the consequent changes of the relative position of the adnexa and uterus.

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With every respect for the learned writer, I find myself unable to accept as accurate the statement "that such pain is common," or that the alteration of the relative position of the uterus and the adnexa has the effect attributed to it. Hermann alludes to this condition under the title, "intermediate dysmenorrhœa," and favours the notion that it depends on the regular monthly maturation of an ovum, the process being painful because the outer part of the ovary is thickened, either from fibrous growth or organised inflammatory lymph. For treatment, he suggests that we should treat the disease of the ovary on which it depends. Christopher Martin writes:—"The pain is regular in its onset, always fourteen days before the next period; it is violent and occurs in paroxysms, and lasts for three or four It is accompanied by a watery discharge from the uterus; in a few cases the discharge is hæmorrhagic, but scanty, so that there is an abortive period in the middle of each interval. On examination, the pelvic organ may be found normal, but there are usually distinct signs of chronic inflammation in the tubes or ovaries. In a considerable number of cases the condition of hydrosalpinx has been found associated with intermenstrual pain, and by most authorities is believed to be the cause thereof."

I have never seen a case in which this pain was "violent and paroxysmal," though this would be easily understood if it were associated with hydrosalpinx, which, in my experience, is by no means common. Intermenstrual pain is generally, though not always, referred to either ovarian region, and sometimes to the right and left sides alternately. In two cases recently under my care it was felt in the breasts alone.

Brief records of some of my cases are as

Case No. 1.—Patient, æt. 34, unmarried, rather delicate from childhood; menstruation came on rather late and has become increasingly painful. At present presents most of the features of wellmarked ovarian dysmenorrhœa; severe pain in groins and tenderness of breasts a few days before the flow appears, attended sometimes with headache and retching. For the past few years severe intermenstrual pain, beginning fourteen days after the first day of preceding illness; no disease of uterus or ovaries discoverable.

Case No. 2.-Patient, æt. 34, healthy aspect, fifteen years married, nine children. About eighteen months after last confinement began to suffer from intermenstrual pain in left side, extending into groin. Examination disclosed nothing more than slight enlargement of uterus and endometritis; no disease of appendages was detected. This patient suffered in a marked degree from

dyspepsia and constipation, for the relief of which she underwent treatment during some months, together, with occasional uterine treatment, and for a time complete relief from the intermenstrual pain was obtained. Amongst other drugs perseveringly used were iodide of potassium and bichloride of mercury. In this case the intermenstrual pain is attended by discharge.

Case No. 3.-Patient, æt. 35, three years married. During her first and only pregnancy, which ended eighteen months ago, was in poor health and her urine was highly albuminous. Uterus somewhat enlarged; os externum small and circular, affording no evidence whatever of parturition having occurred. Some glairy discharge is constantly present; abdominal walls very thick; appendages not distinctly felt. Has suffered much from intermenstrual pain, especially during the last year. Treatment in this case has been followed by much relief, the intermenstrual pain especially having nearly ceased. In my opinion, aspirin contributed to this satisfactory

Case No. 4.-Patient, unmarried, æt. 27; complains much of failing health, loss of weight and energy, and frequent attacks of nausea, especially at meal-time. Menstruation is painful, and a vaginal examination shows that the uterus is low in pelvis and retroverted. In this case the intermenstrual pain is in the breasts, not in the pelvis. Under treatment, local and constitutional, the dysmenorrhœa and nausea were completely cured, and the mammary distress alleviated.

Case No. 5 .- Patient, æt. 41, nine years married. Some months before marriage, following exposure to cold, irregular menstruation and frequent sick headaches were a source of much trouble, and about the same time patient began to suffer from pain and swelling in both breasts, starting a fortnight

before each illness.

Case No. 6 .- Patient, æt. 33, single, troubled with frequent micturition and menstruation, discharge returning every two weeks, attended with swelling and tenderness of breasts. Pelvic conditions, vulvitis and vaginitis; uterus retroverted and adherent; much evidence of endometritis. Several days after each menstruation severe crampy pain is experienced in lower belly, accompanied by red discharge. Treatment afforded but little relief.

Case No. 7 .- Patient, æt. 29, four years married, two children. Suffers much pain in belly, discomfort and vomiting between menstruation; the pain begins on the 20th and lasts till the 28th of each month. Local conditions: laceration and ectropion of cervix, uterine cavity  $3\frac{1}{2}$  inches. Treatment brought about a healthy state of the uterus, but very little diminution of the intermenstrual pain.

Case No. 8 .- Patient, æt. 26, three years married, childless. Chief trouble is headache, beginning one week after, and lasting till one week before men-struation. Nothing worth noting in the condition

of the pelvic organs.

It may be readily understood from the foregoing that treatment must be varied, directed to the removal, if possible, of any ascertained morbid conditions, and, in their absence (and, indeed, in every case), to the improvement of the general health. In a few cases, which have proved not amenable to other measures, the removal of one, or both, ovaries, has been practised, but with results so variable and inconstant that it cannot be advised in future, unless as a last and desperate resource We should, I think, refrain as much as possible from the exhibition of narcotics, especially opium. Perhaps an exception may be made in favour of Indian hemp, especially if given in pill with quinine. It will be well to bear in mind the varying strength

of different samples of this drug, and, in order to avoid the production of sometimes alarming constitutional disturbance, to instruct our patient to take it always shortly after food. Recently I have given aspirin once or twice in the day with encouraging results. Arsenic, too, deserves to be remembered amongst the remedies likely to be of any service.

In my opinion, intermenstrual pain is dependent on, and caused by, the maturation of a Graafian follicle in an ovary itself in a pathological condition, and generally surrounded by structures which have been implicated in an inflammatory process.

Treatment, to be effectual in giving relief should be, constitutional, to improve the general health, and, local, to relieve, as far as may be done, the associated diseased conditions.

# "STITCHES."

# By Prof. HENRI BARTH, M.D., Fhysician to the Necker Hospital, Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

By "stitch" I mean a special kind of pain in the side that occurs as a symptom of certain acute pleuro-pulmonary affections, and constitutes an important factor in the production of dyspnœa, since it is intensified in proportion to the depth of respiration, until it becomes well-nigh intolerable.

Either suddenly or gradually, a person who may either be in good health or has been suffering from some chest affection is seized with spontaneous, intense, strictly localised pain, situated either in the mammary region or at the angle of the shoulder-blade behind. This pain is sometimes dull and continuous, in others lancinating or stabbing, is increased by coughing, deep inspiration and movements of the trunk muscles.

This peculiar pain is due to irritation of one or several sub-pleural nerve fibres by inflammation of the enveloping serous membrane. It is, therefore, essentially a symptom of pleuritis, and, like the latter, may be associated with any affection that involves the pleura or the cortical layers of the lung.

In acute pneumonia the pain in the side is usually present from the onset, except in cases where the phlegmasia has started in the depth of a lobe, in which event it may only supervene at or towards the fifth day, at a time when auscultatory signs reveal the extension of the morbid process towards the surface. This pain is dull, aching, and constant. Its point of maximum intensity is in the sub-mammary region of one or other side. When violent, the patient instinctively holds his breath, and fixes the thorax by inclining the trunk towards the affected side. The voice and cough are jerky, and the efforts required to eject the sputum make

the patient cry out with pain.

This pain rarely lasts for more than forty-eight hours, after which it gradually subsides. Its persistence after the sixth day, or its recurrence after defervescence, is almost always indicative of the

supervention of a secondary pleurisy.

Pain in the side in the course of an attack of bronchitis, unless due to pleurodynia provoked by the cough, may be caused by a focus of broncho-pneumonia extending towards the surface of the lung, and careful auscultation over the seat of the pain will often enable us to detect the physical signs confirming this supposition.

Pneumothorax, especially in the septic form, is ushered in by sudden, very severe, lancinating pain on one side of the thorax, which the patient describes as "stabbing"; it may be so intense as to paralyse the costal movements of respiration, giving rise to very pronounced dyspnœa, especially in cases where the healthy pleura, being quite free from adhesions, offers no obstacle to the complete retraction of the lung, or when the valve-like opening in the lung favours the accumulation of air in the pleural cavity.

Pain in the side is rarely absent in sero-fibrinous pleurisy, and, as a rule, it comes on early. It is generally of a dull aching kind, is intensified by coughing, and subsides as soon as the layers of inflamed pleura become separated by effusion, giving place to a feeling of distension, merging into thoracic fulness when the quantity of fluid increases to such an extent as to exert compression on the subjacent lung and displace the neighbouring viscera. It may once again become sharp when the fluid has been re-absorbed and the false memberanes are being organised into adhesions, and it may possibly persist for months while retraction is going on.

In diaphragramatic pleurisy the pain in the side is due to irritation of the terminal fibres of the phrenic nerve, and is felt along the margin of the left false ribs in front. Pressure on this spot (Mussy's "diaphragmatic button") renders it so severe as to determine symptoms of impending suffocation. In these cases, too, we often meet with spontaneous pain in front of the scaleni on the same side and along the corresponding margin of the sternum. The diaphragm on the affected side

is paralysed and immobile.

In purulent pleurisy, especially in the septic variety, associated with gangrene of the pleura, the pain in the side is of intolerable severity. It may be felt either in front or behind, but it is always strictly localised. The slightest pressure, even that of simple percussion, makes the patient cry out with pain. In contrast with these hyperacute forms is the dull aching pain sometimes met with in tuberculous patients in presence of limited dry pleurisy. The pain is situated at the apices under the shoulder-blade, or, less frequently, under the clavicle. It is of variable intensity, and appears to be influenced by damp cold, which often leads it to be diagnosed as "rheumatic."

A more definite and fixed pain in a tuberculous subject usually indicates the formation of another focus of disease. In these cases, to which Sabourin has recently called attention, the pain in the side coincides with remarkable accuracy with a spot of the pulmonary parenchyma, in which crepitation and blowing sounds may be heard. This may be in the armpit or in the back, generally in close

proximity to an interlobar fossure.

The epigastric spot recently described by Dr. De Brun, of Beyrouth, in pulmonary emphysema, is, according to this observer, consequent upon dilatation of the right heart, and is also met with in mitral affections at the stage of threatening asystole. The pain in question, which was noted in forty-five out of sixty-eight patients suffering from emphysema, is usually situated at the upper part of the xiphoid region. The pain is described as a distressing sensation of weight or epigrastric pressure, sometimes radiating towards the lower dorsal region. It is persistent and is intimately associated with the dyspnœa, becoming worse under the influence of causes that tend to exaggerate the latter and characterised by frequent nocturnal exacerbations. Pressure renders it unbearable. It is always accompanied by hypertrophy of the right heart and visible epigastric pulsation. It is relieved by morphia and the iodides.

False Pains in the Side.—Certain other forms of thoracic pain may be mistaken for "stitch," in consequence of their interference with respiration. They present certain special features, which, in addition to the absence, as shown by auscultation,

of any other sign of pleuro-pulmonary disease, enable us, as a rule, to recognise their nature.

We may mention en passant intercostal neuralgia, recognisable by its half-girdle distribution, running along one or more of the intercostal spaces, the existence of the pain-spots described by Valleix, its paroxysmal aspect, and the zona that sometimes accompanies and explains it. Pleurodynia, which is often consequent upon direct chill, may be identified by its being situated only in the walls, and especially in the muscles, by its vague and mobile character, by the relief afforded by massage and counterirritation. The pain of atheromatous chronic aortitis affects the character of a sub-sternal bar, which is not manifestly affected by the respiratory movements, but is aggravated by the least muscular effort, radiating into the shoulder and left arm. Lastly, the distension pain of gastro-colic, usually referred by patients to the region of the heart, is distinguished by its sudden onset, its acuteness, by the anxiety it inspires, and by its equally rapid subsidence after the eructation of gas or intestinal borborygmi.

# CLINICAL RECORDS.

# NECROSIS OF THE SPLEEN FROM THROMBOSIS OF THE SPLENIC ARTERY.

By F. PARKES WEBER, M.D., F.R.C.P.,

Senior Physician to the German Hospital, London.

The patient was a thin, shrivelled-looking woman, act. 75, who died at the German Hospital in November, 1908, from advanced pulmonary tuberculosis. The pulmonary disease was accompanied by occasional moderate fever, but there was no cough or expectoration. There was no evidence of cardiac disease. The urine contained a trace of albumin. The spleen could not be felt during life, and there were no symptoms drawing attention to that organ. The lower part of the right lobe of the liver extended far down on the right side of the abdomen, so as to simulate an abdominal tumour.

At the necropsy it was found that this lower part of the liver was separated from the upper part by a moderate transverse constriction of the "tight-lacing" kind. Though the liver extended so far downwards, the weight of the organ was only 45 ounces. The gall-bladder contained bile and several small black calculi. The kidneys showed slight interstitial fibrosis. The heart appeared free from disease. The abdominal aorta and its branches showed much atheromatous change.

The spleen (weight about 12 ounces) was somewhat enlarged and hard, and of a peculiar brownish colour on section. It contained some whitish and two or three red, infarct-shaped patches. The splenic artery and its branches were thickened and calcified, and completely occluded by recent dark thrombus.

Microscopic sections of several pieces of the spleen (for most of which I am indebted to Dr. Chapuis) showed that the white areas were not the only necrotic portions, but that the substance of the whole organ, with the exception of the alreadymentioned red patches, had undergone a similar degeneration. In most parts the nuclei of all the cells, excepting the lymphocytes of the Malpighian follicles (illustrating the relatively great resistance of the lymphocytes to necrotic processes), had disappeared (karyolysis). In some parts, especially near the splenic capsule, another form of degeneration with karyorrhexis was to be observed. The

arteries were much diseased, and many of the intrasplenic blood-vessels were thrombosed.

The increase in the size of the spleen was evidently the indirect result of the chronic disease of the splenic artery and its branches without and within the organ, whilst the recent complete occlusion of the main arterial trunk had practically converted the whole organ into one big infarct. The necrosis of the different portions of the organ was evidently not all of the same date, some of the arterial divisions having evidently been occluded before the others, but it is not quite clear why in the two or three sharply-defined (infarct-shaped) red patches necrosis had apparently not yet occurred. If septic changes had continued to remain absent, and if the patient had lived long enough, the spleen would probably have been ultimately replaced by fibrous tissue, which would have gradually contracted like the scar following an ordinary infarct.

In the literature at hand on diseases of the spleen I have come across no reference to any case quite similar to the present one, but it is well-known that non-septic necrosis and atrophy may follow torsion of the pedicle of a "wandering" spleen, when the torsion is of sufficient degree to cause vascular ccclusion. In Professor M. Litten's account of "Diseases of the Spleen" (German edition, Vienna, 1898, page 32), in Nothnagel's great "System," the author points out that a "wandering" spleen may, by torsion of its pedicle, not only become necrotic and atrophied, but may even, by gradual atrophy of its pedicle (with, perhaps, some slight final traumatism), come to lie free in the abdomen. Dr. J. C. G. Ledingham kindly informs me that he remembers having been present at a necropsy apparently illustrating this sequence of events, for a shrivelled, degenerated spleen was found lying unattached in the peritoneal cavity.

# OPERATING THEATRES.

GUY'S HOSPITAL.

LATERAL SINUS THROMBOSIS AND CEREBRAL ABSCESS.—MR. R. P. ROWLANDS operated on a boy, æt. 17, who had been admitted for pyrexia supposed to be due to typhoid. Shortly after admission the patient had a rigor, and, on inquiry, it was discovered he had had two others shortly before admission. There was a slight discharge from the right ear, and he was tender in the upper part of the neck on the same side. Lateral thrombosis secondary to mastoid disease was the diagnosis. The mastoid antrum was opened, and the lateral sinus explored. Lateral sinus thrombosis was discovered. The horizontal part of the sinus was plugged, and the internal jugular vein tied close to the clavicle. The thrombosis was early, and there was pus in the bony canal surrounding the vein. The pus was evacuated, and the horizontal part of the sinus plugged in order to prevent blood flowing over the septic clot in the sinus. The wound was drained with gauze. Mr. Rowlands said that in lateral sinus thrombosis there was no complete obstruction, and that the dissemination of the infection was due to this fact, septic emboli being carried to the lungs and elsewhere by the stream of blood passing over the infective clot

septic emboli being carried to the lungs and elsewhere by the stream of blood passing over the infective clot. The boy progressed favourably for a few days, but at the end of a week the mental condition became a little blurred, and the temperature, which had come down to normal, went up again to 103°. His manner and actions were strange and unreasonable, though not violent; he wasted rapidly, and was constipated. The right pupil became smaller than the left, and there was early optic neuritis. It was therefore concluded that there was a temporo-sphenoidal abscess. The wound was re-opened, and the roof of the antrum removed with a small piece of the outer wall of the squamous portion of the temporal. The brain was explored with a needle, which was passed into the brain in several

directions until pus was found low down. A knife was passed along the needle into the cavity, and a drainage tube inserted and sewn to the skin.

Mr. Rowlands said that the interesting points of the case were the importance of rigors in the diagnosis of lateral sinus thrombosis when associated with the slightest discharge from the ear. The tenderness along the upper part of the internal jugular vein was also of great diagnostic importance, and also the pain elicited by percussion of the mastoid process. The mortality of lateral sinus thrombosis is, he remarked, very great unless an early operation is performed, in fact, immediately after the condition is reasonably suspected. It is of paramount importance, he considered, to block the central part of the lateral sinus so as to prevent embolic infection. For the same reason the internal jugular vein is tied low down in the neck. It is well to leave a plug in the sinus for about four days, at this period little or no bleeding occurs on its removal; only in the event of any hæmorrhage occurring, a fresh plug would be introduced. Mr. Row-lands pointed out that the tympanum was left un-touched (except for drainage through the mastoid) in order to save the hearing as much as possible. The mastoid cells and the outer wall of the mastoid process, of course, were removed freely. He pointed out that the plug is originally placed between the fibrous covering of the sinus and the bone (extra durally) so as to occlude the former without risk of spreading septic thrombosis centrally into the other cranial sinuses. With reference to the diagnosis of the early temporo-sphenoidal abscess, he said one had to rely mainly on the curious and characteristic mental condition, the high temperature and the early optic neuritis, the wasting and the constipation; there was no vomiting and no headache. To explore this region the simplest and best plan is to enlarge the wound in the mastoid bone upwards and slightly forwards so as to expose the dura mater in the outer floor of the middle fossa. The advantages of this method are that excellent drainage is provided and the abscess is more easily and certainly found, because it is always in close proximity to the diseased bone. Besides no troublesome gap is left in the skull. He considered it to be of great importance to sew the tube to the edges of the skin wound so that it may not slip out, as its re-introduction would be difficult and perilous. The tube should not be disturbed for three days, so that a good passage may be established along the track, thus rendering re-introduction easy and without danger. It is important also to continue the drainage for a sufficient length of time in order to obviate any chances of re-collection of pus in the abscess cavity.

The patient's convalescence was uninterrupted. He had a chronic sinus for some time, leading down to the mastoid. The drainage tube into the brain was discontinued after ten days, and the patient left the hospital five weeks after operation. Mr. Rowlands has seen him several times since in the out-patient room; his progress has been good, the wounds were healed, there was no discharge from the ear, and the hearing of the right ear is fair.

# TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, DECEMBER 11TH, 1908.

The President, Dr. E. HASTINGS TWEEDY, in the Chair.

EXHIBITS.

A MODIFICATION OF BANDL'S HOLLOW SOUND.

DR. WILSON exhibited a modification of Bandl's hollow sound, which did away with the difficulty in the mechanical cleaning of the instrument.

The President considered the exhibit a great improvement on any other Bandl's sound that he had

Dr. FITZGIBBON thought the instrument as modified would much more serviceably carry and apply whatever fluid was used.

Dr. ASHE said he had tried the instrument on 200 women last year, and found it of use.

Dr. Tweedy exhibited specimens of

(a) HYPERNEPHROMA; (b) TUMOURS FROM A CASE OF RECURRENT FIBROIDS.

(a) A. M., æt. 57, widow; 15-para; last pregnancy 13 years ago.

History.—Has noticed tumour in side for three years;

increased latterly in size.

Physical Signs.—A large cystic tumour, very fixed, extending on left side from pubic brim to kidney region. A cord-like mass felt through rectum was diagnosed as ovarian pedicle, and a diagnosis of probable ovarian cyst made. On opening the abdomen a large retroperitoneal cyst came into view. The great omentum surrounded it on all sides. Numerous adhesions to intestines. The omentum was with difficulty separated, and enormous vessels tied. During the process the tumour ruptured, and about two pints of pus escaped. The pedicle was reached, and the tumour was discovered to be renal in origin. Pedicle was secured with catgut, and the ureter divided and stitched into abdominal wall. A gauze wick was in serted to provide an escape for oozing. Uninterrupted recovery.

Hypernephroma was a somewhat rare tumour. first case in which a kidney was removed, a diagnosis of ovarian cyst having been made, was temoved, a diagnosis of ovarian cyst having been made, was by the late Mr. Lawson Tait, and everyone was amazed at his statement that he believed it was an ovarian tumour until the pathologist told him it was a kidney.

(b) February 17th, 1908.—M. A., æt. 70.

History.-For past two years has bled on and off. In June, 1907, bleeding got worse, and has continued ever since. Lately has become more of a discharge.

Physical Signs.—Sloughing polypus protruding from vagina.

Operation.—Large amount of sloughing material

taken away by vagina.

Pathological Reports-Macroscopic.—(1) White, rough mass, size of hazel nut; myoma or malignant. (2) White, friable masses; necrosed myomata. (3) Torn masses of fibroids; purulent exudate. Microscopic.—
(1) Highly cellular tissue, with blood vessels. Cells show some irregularity in size, but are not decidedly

malignant. (2) Necrotic myoma.

November 10th, 1908.—Complaint.—Passing fleshylooking masses by vagina from time to time.

Physical Signs.—Broad pedicled polypus attached to

Diagnosis.—Polypus; malignant?

Operation.—Amputation by vagina.

Pathological Report — Macroscopic. — Soft, friable masses. Microscopic.—Necrosed fibrous and muscle tissue.

This tumour was found in the vagina of a lady, æt. 71. She had come to him ten years ago, stating that the late Dr. Mason had removed a number of myomata from her. She at this time suffered from a vaginal polypus, which came away without operative help. At intervals since this she had returned to him bringing myomas which had passed from her. In May last he removed an enormous sloughing mass, which Dr. Rowlette said was possibly malignant, though he was inclined to think it was a myoma. She went away in good health, but came back about a fortnight ago very ill, when he removed a similar mass. Again Dr. Rowlette reported it to be a myoma. The woman's uterus was not bigger than a shut thumb, and there

was no myoma in it, so far as he could now ascertain.

Dr. Rowlette said he had seen two or three hypernephromas shown by others. The tumour was usually situated apparently in the kidney, and was supposed to originate from the adrenal body. The structural connection was not at all clear in most cases, but, from the histology of the tumour, it more closely resembled, where the type was well retained, the structure of the adrenal body than the kidney itself. Degeneration was fairly common in the tumour, but in the few instances that he had seen he had not observed so much de-

generation as in the case before them. Microscopically the material resembled pus, though they were unable to isolate any micro-organism. It was difficult to obtain good microscopic section in the case of the recurrent fibroids, as the material from the tumours was always proportion of semi-proportion but he could be applied to the recurrent fibroids. always necrotic or semi-necrotic, but he could come to no other opinion than that it was necrosed fibromuscular tissue. He found nothing to suggest any malignant change.

16 THE MEDICAL PRESS.

Dr. Pureroy recalled cases in his own experience showing that what appeared to be an ovarian cyst might prove to be renal. He also had had the experience of repeatedly removing a large sloughing mass, which was apparently ordinary fibro-myoma. He thought it was only after the third operation that they discovered evidence of sarcoma. Ultimately he performed hysterectomy, but the patient did not recover.

The PRESIDENT, in reply, said the patient was never in a condition that would enable him to remove the uterus. She never came to him until she was at the point of death. His object then was to remove the mass at once, and he was always convinced that it was the last time he would see her.

Dr. R. D. Purefor, formerly Master of the Rotunda

Hospital, read a paper on

#### INTERMENSTRUAL PAIN.

which will be found in another column under the heading of "Original Papers," page II.

Dr. FitzGibbon also read a paper on the same subject for Dr. Spencer Sheill, which will appear in these columns next week.

In the discussion that followed, Dr. WILSON remarked that he thought that where there were evident local lesions, which could be corrected, with the result that the pain ceased, it hardly came under the head of intermenstrual pain; neither did cases in which congestion of the ovaries was relieved by the loss of blood at the period. The difficulty of treating cases of pain that came on a definite number of days after a menstrual period, and ceased a definite number of days before a period, was very great, and although of days octobe a period, was telly given, and annually the drugs mentioned might give relief, it was a matter of considerable doubt as to what the condition really

Dr. Ashe considered the condition was probably due to some form of toxemia arising from an excess of internal secretion of the ovary.

Dr. NEILL remarked that salicylate of menthol had

recently been advised for relief of pain.

Dr. FITZGIBBON said that in speaking of intermenstrual pain there was a tendency to mix up a variety of different diseases. They should keep in mind that the pain should be one which occurred at a fixed time between the periods, and in which there was no definite organic disease. The ignorance which existed as to ovulation made it difficult to say certainly that it was congestion of the ovary that caused the pain, but he expected that Dr. Sheill's suggestion of circulatory treatment would improve the condition.

Dr. Katherine Maguire said she did not find the

condition common in an excessive degree. She found aspirin rather a dangerous drug, as far as its gastric symptoms were concerned, though it certainly relieved She found phenacetin to do good. If ammonol or antikamnia were given, they should be given after food, and with tea or coffee, which neutralised their effects. She regarded both drugs as dangerous be-

cause they were compounds of antifebrin.

The President said that women suffered from constipation and congestion of the pelvic organs, and he believed that this congestion would be relieved by free purging better than by the drugs mentioned. He thought that in most cases, not due to constipation or neurasthenia, they would find some disease of the tubes which might give no evidence of their condition to the examining finger.

Dr. Purefoy, in reply, said he agreed with Dr.

FitzGibbon's limitation of cases, but such typical cases were rare. He was very sparing in his pre-scription of drugs, and considered that anything like repeated use of the coal-tar remedies was greatly to be deprecated.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY

MEETING HELD ON FRIDAY, DECEMBER 18TH, 1908.

The President, Dr. A. J. WALLACE (Liverpool), in the Chair.

EXHIBITION OF SPECIMENS AND CASES.

DR. Donald (Manchester) showed a broad ligament cyst of doubtful origin, having a squamouscelled lining.

Dr. Fitzgerald exhibited a specimen of early unruptured tubal gestation.

Dr. Lloyd Roberts (Manchester) showed (1) a fibroid polyp of the uterus, undergoing extrusion, removed from a patient, æt. 39, primipara, who suffered from menorrhagia. Angiomatous changes in its structure were demonstrated microscopically. (2) A uterine fibroid undergoing cystic degeneration.

Miss Frances Ives (Liverpool) communicated three cases of ectopic gestation, and showed the specimens and microscopical sections. (1) An early unruptured tubal pregnancy occurring in a young lady, married 15 months, who had an attack of pelvic pain 14 days after a normal menstrual period. The pain recurred ten days later, and per vaginam the right ovary was the size of an orange, and some thickening could be detected in the left Fallopian tube. Abdominal section revealed a patent left tube, in the ampullary portion of which a plum-coloured swelling, \(\frac{1}{2}\) in. in diameter, was situated. The left ovary was also cystic, and was removed with the pregnant tube. The right ovary formed the larger cyst, but partial resection was possible, and healthy ovarian tissue was left near Sections from the middle of the swelling showed the intra-muscular site of the ovum. (2) Serial sections of the Fallopian tube in a case of peri-tubal hæmatocele removed from a multipara who had profuse irregular bleeding following a scanty period at the usual time. The undilated tube was found closely associated with a mass of blood clot at its fimbriated end. It was permeable throughout, except at one spot, where the lumen was encroached upon by a small mass of organising fibrin and old blood clot, due to either a tubal mole nearly absorbed or to an incomplete tubal abortion. No traces of chorionic villi could be seen. (3) A tubal mole without hæmatocele occurring in a married woman æt. 34. II.-para, in whom six weeks' amenorrhœa was followed by three weeks' moderate hæmorrhage.

Dr. W. K. Walls (Manchester) brought forward a case of rupture of the uterus. The patient, æt. 32, was admitted to St. Mary's Hospital, following an abortion, in the treatment of which dilatation of the cervix by tents and the evacuation of the uterus had been performed by her doctor. Several feet of small intestine, separated from its mesentery, protruded from the vulva. Laparotomy and end-to-end anastomosis was performed, but death occurred suddenly on the fifth day. At the autopsy primary healing of the bowel had taken place.

Dr. Grimsdale (Liverpool) recorded the case of a patient, married at the age of 42, who consulted him a year afterwards on account of "dyspareunia." The vagina would only admit the little finger, and that with some difficulty. Dilatation of the vagina was suggested, but was not carried out. Nine months later she returned complaining of symptoms suggesting pregnancy, and on examination it was found that she was three months pregnant, the vagina now admitting the index finger with considerable difficulty. On several occasions during the pregnancy vaginal examinations were made, but the tissues continued to be very rigid. After much consideration it was recom-mended that a Cæsarean section would offer the best prospect to the mother and child. This was accord-

ingly done at the full term, with the best result.

Dr. A. J. WALLACE delivered his Presidential Address, in which were reviewed briefly the recent

tendencies to the adoption of

CONSERVATIVE METHODS OF TREATMENT IN CASES OF PELVIC INFLAMMATORY DISEASE IN THE FEMALE.

Particular reference was made to the "Belastung" therapy and to the application of Bier's hyperæmic treatment to gynæcological cases, and Hörrmann's account of the striking results obtained in J. A. Amann's Klinik was referred to in some detail. While admitting the favourable influence exercised by hot-air hyperæmia in non-suppurative disease, it was necessary to recognise that the evidence up to the present was decidedly in favour of surgical interference in pus cases. After animadverting on the neglect on the part of the gynæcologist to take up the question of the prophylaxis of pelvic inflammatory disease, and reference to the measures that were being taken in other countries, the Address dealt with the relations between general surgery, obstetrics and gynæcology.

# CORRESPONDENCE.

### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

# FRANCE.

Paris, Jan. 3rd, 1909.

CUTANEOUS DRAINAGE.

THE ideal method for removing cedema is that which consists in eliminating by the kidneys the liquid effused into the skin and the cellular tissue: massage, milk diet, and digitalis in cardiac disease, or theobromin in persons suffering from Bright's disease with dechloruration. Such are the means more generally employed.

There are cases, however, where, in spite of the most intelligent medical treatment, the cedema, instead of diminishing, remains stationary or increases to the extent that anasarca invades the lower limbs, the scrotum, the abdominal walls, etc. The patient can no longer lie down, passes his nights in a chair, while dyspnea, due to the ædema which has probably invaded the peritoneum, the pleura, the pericardium, and intoxication of the bulb produced by the retention of the elements of the urine, is very marked.

In such cases it is necessary to evacuate the ædema by cutaneous drainage. There are thus two principal indications to drainage: irreducibility of the cedema and intolerance of the patient towards this cedema. The counter-indications are: œdema due to compression, which can always be rectified, and elephantiasis

from stasis of the lymph. Drainage can be effected by acupuncture, incision, or the trocar. For either of these operations the skin should be disinfected by washing with ether or alcohol, both sufficiently antiseptic and possessing further the advantage of removing all trace of grease. The drainage should be made, says Dr. Milian, behind the malleolus of the ankle for a patient keeping the sitting position, and on the inside of the thigh for the

borizontal position.

The instrument for making the puncture is the The wound should be a quarter of an inch is length, intersecting the whole thickness of the skin so as to attain the cellular tissue beneath. The liquid of the cedema trickles immediately from the incision. lacisions are made with the bistoury. Recommended by Furbinger, they are seldom employed to-day as they are painful and heal with difficulty. Three or four thes in length, they go right down to the aponeurosis and are drawn in the axis of the limb.

The liquid flows in more or less abundance and that continuously, as the distended and ill-nourished tegunents have no tendency to heal spontaneously. Unless recautions are taken, the liquid will traverse the near of the patient, the bed, and even the mattress. from of the patient, the bed, and even the mattress. Consequently the mattress should be protected by apermeable cloth, passed under the sheet, a thrice-filded sheet placed under the patient and changed they day, while irritation of the teguments should be strong around the wound of a slightly exented by a coating around the wound of a slightly intiseptic paste:

Resorcin, 15 gr. Oxide of zinc, 4 dr. Vaseline, 4 dr.

Lanoline, 4 dr.

The limb is afterwards enveloped in a thick layer of absorbent wool, which is changed as frequently as

necessary.

The inconvenience of these punctures or incisions lies precisely in this constant wetting, which exposes the patient to pulmonary complications, as bronchopneumonia, in spite of every protection. To guarantee against these possibilities, drainage by trocars is recommended. By this method the liquid is conducted directly from the cellular tissue to a receptacle, thus avoiding wetting the patient.

The models of trocars are various, but the principal are those of Southey and Curschmann. The latter has the advantage of being larger, and thus not so easily obstructed by a clot. A more simple method is that of an ordinary drainage rubber tube of 1 to 2 ft. in length, and passed underneath the skin in the form of a seton, leaving the ends hanging down, through which the liquid flows. The duration of the drainage

should not exceed 24 hours.

Among the complications may be mentioned slight delirium or obnubilation. Gumbrecht cites the case of a young girl who was very anæmic, and suffered from chronic nephritis, with general anasarca. Several trocars were placed in the legs, giving issue to 20 quarts of liquid in the two hours. The night following she died, and the immediate cause of death was believed to be anæmia of the brain. Again the little wound is frequently inclined to become fistulous and run continuously. But the most serious complication is infection (lymphangitis, erysipelas) from absence of cleanliness.

In spite of these possible disadvantages, mechanical drainage can give considerable relief where therapeutic

agents have failed.

### GERMANY.

Berlin, Jan. 373, 1909 Ar the Verein für Innere Medizin, Hr. Senator spoke

INFLUENCE OF THE BODY TEMPERATURE ON THE SUGAR CONSTITUENT OF THE BLOOD. He said that Lüthje, as well as his pupils and collaborators, found that in dogs, from which the pancreas had been removed, the sugar excretion, and in normal dogs the sugar of the blood increased with fall of the outer temperature, and diminished when the outside temperature rose. In the meantime these statements had been contradicted by several authors (Minkowski, Mohr). Even in phloridzin diabetes such an influence had not been established. One point had not been considered, and that was, the behaviour of the temperature in the various temperature-surroundings. In men and the so-called homothermous animals their temperatures remained normal during varied external temperatures in virtue of their heat regulating external temperatures in virtue of their near regulating functions, but only within certain limits, which, as the speaker had shown 40 years ago, in the case of fasting, unclothed, and non-moving individuals lay between 27 and 35° C., i.e., between these limits he could keep his body temperature nearly constant. Whether to allow wider limits, in the case of animals with varieties of averaged temperature of 30° and with variations of external temperature of 20° and over, was more than doubtful.

The influence of the body temperature in the formation and excretion of sugar had not yet been brought to a conclusion; statements regarding the excretion of sugar in diabetics when in a feverish condition were contradictory; according to recent statements there was an increase of excretion during rises of temperature. There was a similar contradiction in temperature. regard to alimentary glycosuria in fever. Thus in the human subject in infective diseases with high temperature there was said to be a strong tendency to alimentary glycosuria, whilst other authors disputed this. P. F. Richter never saw glycosuria during the hyperæmia of rabbits after Sachs-Aronsohn's brain puncture. Aronsohn saw adrenalin glycosuria disappear after similar puncture, others did not see it.

The statements regarding the sugar constituent of the blood in heightened temperatures were also at variance. The same applied to the supply of glycogen of the body.

In all these various investigations the fundamental question had practically not been discussed at all, how the raising of the body temperature itself acted on the sugar constituent of the blood. For this reason the speaker had himself taken the subject up. For the production of such temperatures there were two methods to hand: retention of the body heat by raising the outside temperature, and the "warm" puncture.

(1) As regards this we had only the experiments of Noel Paton, which gave a rather considerable increase of the sugar constituent. The speaker scarcely ever succeeded in keeping rabbits alive many hours with an uninterrupted high temperature. Only twice did animals remain alive 4 or 5 hours. They were fed several days beforehand, their temperatures taken once or twice a day, and their urine tested for albumin and sugar; 20 to 25 c.cm. of blood were then taken from one of the carotids, and the sugar constituent ascertained. Some days later, when no deviation from the normal was observed in the animal, the artificial warming was begun, and after some hours blood was taken from the other carotid. In both cases a distinct increase of the sugar constituent was determined, which must clearly be looked upon as a consequence of the raised temperature.

(2) Up to the present there were no investigations on this point. He himself had made ten experiments on nine animals, which, without exception, showed an increase of the sugar constituent after rise of temperature, and from 8 per cent. to 30 per cent. with an average of 17.2 per cent. In both series of experiments the urine was perfectly free from sugar, as the sugar constituent, although increased, was not high enough to cause glycosuria. In order to decide the question whether in the case of the "warm" puncture other elements play a part—irritation or paralysis of nerves he tried to prevent the rise of temperature by cooling. This experiment, however, failed, as the rabbits were very sensitive to it and quickly collapsed. Anti-thermic medicines could not be tried, as the carbohydrates of the system were especially influenced by them, glycogen turned into sugar, even glycosuria might be set un

on what did this increase of sugar depend? Two possibilities here came into consideration: (1) More glycogen might reach the blood from the glycogenforming organs (liver and muscles); (2) the cause of the rise might be decomposition of albumin; as was known sugar might be split off even from albumin.

As regarded the influence of the infective fever-high temperature on the sugar constituent of the blood, the raising of the temperature and of the fatty albumin increased it. Inversely the bacteria or the products of their tissue changes, causing the infective process, might lower it; the condition of the patient as regarded nutrition was further of influence. From this, according to the predominance of the various factors, the varying statements as regarded fever were to be explained.

The speaker then quoted the observation of v. Noorden, according to which, in a pneumonic patient with a large sugar constituent of the blood, no glycosuria took place, which v. Noorden attributed to an imperviousness to sugar of the kidney, dependent on the febrile affection.

# AUSTRIA.

Vienna, Jan. 3rd, 1909.

MENINGO-COCCI SERUM.

At the Gesellschaft, Kraus and Baecher gave proof of their new serum for meningitis, with which they have been experimenting for some time past, both in the Sero-Therapeutic Institute and the wards of the Children's Hospital. The first proof was by the opsonic method of Neufeld, which, as expected, was quite satisfactory. The next was the application, the most important of all. They prefer Pfeiffer's form of

injecting it into the peritoneum, where both anti-toxic and opsonic power can be accurately measured. The therapeutic results which they have obtained in hospital are that two-thirds of the hopeless cases have recovered. The cases selected were those given up as hopeless, so that mild conditions have not yet been tested.

ABSCESS IN TEMPORAL LOBE.

Ferdinand presented a young woman, æt 17, cq whom he had operated for abscess in the right temporal region of the brain. She had suffered for ten years from purulent discharges from the right ear and antrum, for which she came to hospital for radical cure. This operation was performed in the usual manner, and all went on well till the ninth day, when she suddenly took a fit and remained unconscious for some time. These epileptic fits repeated themselves till the fifteenth day after the operation, when she commenced to complain of severe pain in the right side of the head. It was then resolved to open up the cranium, as the temperature had risen to 38.4 Cent., or 105.12° F., and insensibility deepening, while the mouth was drawn to the left from pressure on the facial nerve, with stiffness in the neck and acute reflex, all indicating central disturbance, as the fundus was healthy.

The wound was re-opened, and the healthy granulating tissue removed with the whole tympanum and antrum, making an opening through the dura mater an inch wide. The dura mater, when reached, was healthy-looking, but vaulted or blown out. In the temporal lobe, about a centimetre below the dura mater, an abscess was found containing a tablespoonful of putrid, offensive-smelling pus. The whole was cleaned cut and dressed antiseptically, with the result that seven weeks after the operation she is perfectly well again.

HYDRO-URETERS AND PROSTATIC HYPERTROPHY. Tandler and Zuckerkandl gave an exhaustive anatomical and ætiological description of hydro-ureters, or, as they are sometimes described, plicæ uretericæ, or, in simple language, a bending and clipping of the ureters between the bladder and the kidney. We have always been taught that hypertrophy of the prostate leads to distension of the bladder and ureter from the undue retention of the urine. Tandler and Zuckerkandl have challenged this theory, and now maintain that the hypertrophy of the prostate acts in a directly anatomical fashion by raising the trigonum upwards behind and jamming the loose ureter against the vas deferens makes a sharp bend in the ureters that hold back the urine from passing on to the bladder, and thus causing distension of the ureter above the kink. From this reasoning the ureter is not affected by the retention of urine in the bladder, but from the increase of the middle lobe of the prostate distorting the position of the trigonum upwards and outwards till the uneter gets entangled and warped with the vas deferens. It is therefore not necessary to assume that the purulent discharge from the upper part is an ascending infection, as this is often present when the bladder is perfectly aseptic. It is more correct to assume a harmatogenous infection in these cases; therefore, infection is not always in consonance with the state of the bladder, or vice versa.

The correct therapy in severe cases of hypertrophy of the prostate would be to cut the vas deferens. This operation has been done recently in a more indirect way by castration, which has the effect of causing the vas deferens to wither and shrink, allowing more freedom for the functional action of the ureter.

Intermitting Ectasia of Stomach.

INTERMITTING ECTASIA OF STOMACH.

Zweig showed two men who, for a few weeks or months at a time, are troubled with insufficient action of the stomach, vomiting food taken the previous day with decided dilatation of the organ. All at once, as by magic, these adverse symptoms disappear, and the patient feels well and can enjoy any kind of food. The real cause seems to depend on a spastic condition of the pylorus, which has led to ectasia and hypertrophy of the gastric muscles. The cause may be nervous, or due to slight ulceration, or fissures in the pylorus. The therapy pointed to fluid diet, washing out of the organ with the oil cure.

Schwarz said that it often occurred that by want of

co-ordination the gastric muscles were thrown into

spasm when the pylorus was perfectly patent.
Escherich was of opinion that pyloric spasm was more frequent in the infant than the adult, which may be due in many cases to the improper constituents of the milk

Schmidt thought that stenosis in these cases had not been logically excluded, but Zweig replied that he found it difficult to exclude this suggestion, but the sudden and healthy intervals were very difficult to explain after such diagnosis.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

SIR DONALD CURRIE'S OFFER TO THE NEW PERTH INFIRMARY.—The following correspondence in reference To Sir Donald Currie's offer has been published:—
"Dec. 22nd, 1908.—Dear Sir Donald,—The Lord
Provost submitted your letter of November 28th to
him to the directors, who, yielding to a strong expression of public opinion, exceedingly regret to inform you that they do not see their way to accepting the offer contained in your letter owing to the time limit imposed by you, and your condition as to the appointment of an architect. Notwithstanding this, I am desired to express the hope that you may see your way to give them a smaller contribution towards the cost of a new infirmary, which has now been resolved upon.—Yours faithfully, PAT. MARTIN, Secretary."—Dec. 28th, 1908.—Dear Sir,—I beg to acknowledge receipt of your letter of the 22nd inst., which has been forwarded to me from Perthshire, and I gather from what appears in the public Press that the friends of the Perth Infirmary see their way to provide the funds which are necessary for a new building without the help which I offered to the Lord Provost in response to an appeal he, with Mr. and Mrs. Murray, of Taymount, made to me at Garth. In my letter to Lord I was prepared to help.—Yours truly, DONALD CURRIE." Provost Cuthbert I stated explicitly the terms on which

EDISBURGH ROYAL INFIRMARY—MEMORIAL TO THE 1 ATE MISS SPENCER.—There was unveiled on the last day of the year, in the chapel of the Infirmary, a mural tablet to the memory of the late Miss Frances Elizabeth Spencer, who for so many years was superintendent of nurses in the institution. After a short service by the chaplain, Mrs. George Kerr, on behalf of the managers, unveiled the tablet, which consists of a brass plate with a wrought inscription bearing that the tablet was erected on the unanimous resolution of the managers in grateful recognition of Miss Spencer's devoted and valuable services. The inscription is encircled by a wreath of oak leaves and acorns,

and the brass is set on a slab of statuary marble.

Annual Report.—The annual report, which is to be submitted to the statutory meeting of the contributors on Monday, January 4th, has just been issued. Apart from the usual statistical matter, it contains little of general interest. During the year 11,754 in-patients were treated: cured, 6,285; relieved, 3,444; discharged for other reasons, 380; died, 823; remaining under treatment, 822. Of the cases terminating as above, 4,104 were medical, 6,828 surgical. In comparison 4,104 were medical, 6,828 surgical. In comparison with last year, the numbers show an increase of 614; the average daily number of patients was 836, against 832; of children, 76, against 82; the average duration of treatment was 26.4 days, as against 27.3 days. Of cases admitted, Edinburgh furnished 5,823; Leith, 436; the country, 4,716. The death-rate was 7 per cent., as against 7.31; deducting 154 deaths within 48 hours of admission, it was 5.76 per cent., or 0.7 per cent. more than last year. The number of out-patients was more than last year. The number of out-patients was \$6,892. The ordinary income was £35,304, a decrease of £402, and the ordinary expenditure was £34.955, an increase of £1,476, due largely to enhanced cost of many articles in use. The entire ordinary expenditure (including out-patient department) per occupied bed was £65 148. 8\frac{1}{4}d., or an increase of £1 98. 2d. over 1907. New Works.—During the year the drainage and structural alterations, and the hot-water installation

and renewal of electrical fittings have been completed in the central surgical block. This completes the great scheme of re-drainage started eight years ago. Sundry improvements to obviate risks from fire have been introduced, and a number of other minor alterations have been made. The new medical out-patient department has been commenced, and will, it is hoped, be completed by the end of February. The principal changes on the staff have been the resignation of Dr. Murdoch Brown on account of the state of his health, and the translation of Mr. Caird from the ordinary surgical staff to the office of Professor of Clinical Surgery, upon the important duties of which he enters "sustained by the esteem and followed by the best wishes of all who have hitherto been associated with him in his work."

# BELFAST

PUBLIC HEALTH.—If the statistics given at the meeting of the City Council on New Year's Day are to be relied upon, Belfast is to be congratulated on a very marked improvement in the public health. For the last four weeks of the year the total deathrate from all causes was 17.7, and from zymotic diseases 0.4, as compared with 25.8 from all causes, and 3.0 from zymotic diseases in the same period last year. The death-rate for the year showed a reduction in every department except that of infant mortality when compared with that of the previous year, and the infant mortality only showed a fractional increase; probably owing to the severe weather in the beginning of the year. Even this, however, is rather disappointing, as after the active work of the Infant Mortality section of the Irish Women's Health Association one would have hoped for a marked decrease. The total death-rate for the year, calculated on the Irish Registrar-General's basis, was 19.3, while calculated on the English and Scotch bases, it should only be 17.5. In any case, it is a marked improvement on former years, and evidently the expenditure on the Health Commission, high as it was, was well-spent money. During the last month of the year there were four cases of cerebro-spinal meningitis notified, showing that the disease is not yet extinct.

THE UNIVERSITY COMMISSION.—The Commissioners who are entrusted with the task of drawing up the statutes and regulations of the new Queen's University statutes and regulations of the new Queen's University of Belfast have been meeting daily since the 29th ult. They are His Honour Judge Shaw, K.C., Chairman; Rev. Thos. Hamilton, Vice-Chancellor; Professor Dill, Sir Donald MacAlister, Mr. R. T. Martin, Sir Arthur Rucker, and Professor Symington. Meetings of the professors in the various faculties have drawn out a will able of study and examinations for each faculty. syllabus of study and examinations for each faculty, and these are being considered by the Commission. It is understood that the plans of the Royal University will be departed from in several important respects as regards the medical curriculum, at any rate. The views of the Commissioners are not known, of course, but the general opinion is that the preliminary year of Arts study will be dropped, allowing the student, after a searching matriculation examination, to enter at once on his professional studies. The Senate of the University has also met, and has appointed a building committee to inquire at once into the question of the new buildings that will be needed.

# LIVERPOOL.

MUSCARINE AND NEURITIS.—A peculiar case came before the Liverpool Coroner on December 23rd when inquiring into the cause of a Mr. Gilman's death neuritis or muscarine.

The facts briefly are:—Gilman, æt. 33, a "ship-owner's manager," was going on his holiday to Wales, and, being troubled with gnats, took with him, on the advice of a friend, a liniment from a homoeopathic establishment containing muscarine to counteract or allay the irritation of gnat bites.

His wife told the jury he used it "for several nights on his arms and legs." But why on the legs for gnat bites? "When they returned home on September

26th," she further tells us, "he lapsed into his former state of health." From this one would infer that deceased was in a bad state of health before they went on their holiday; but what he was suffering from at that time we have no further knowledge.

On his return home the medical testimony commences with multiple neuritis, which all agree to be present, but the proximate cause is a puzzle, as the deceased was a very abstemious man and never exposed to any of the probable causes usually associated with this disease! Was it this liniment that was used for gnat bites or some other poison? This lotion, according to the biological chemist, contained alcohol and soap with "a small amount of 'muscarine' found in certain fungi, by both chemical and physiological tests, which has the property of stopping the heart in a relaxed condition, and causing paralysis of the nervous system." At the post-mortem, "the body was well nourished, healthy, and muscular." "All the organs were healthy, with considerable congestion of both lungs, heart and intestines." "He had all the symptoms of having died from failure of heart and respiration."

Now here is a puzzle to place before a coroner and a jury by three wiseacres of the profession! All seem to agree in peripheral neuritis, but none took the trouble to confirm it. One ventures on muscarine poisoning from the lotion, affirming that it acted more potently when applied to the cutaneous surface than when taken internally. Would such a small quantity produce peripheral neuritis? And, furthermore, could the poison remain in the body from September 26th to December 10th—nearly three months—and finally kill by cardiac diastole? It was suggested that he must have used it later than September 26th, but one cannot see any reason for doing this, as no gnats were likely to trouble him about the Mersey

The cryptic evidence of the wife that "he lapsed into his former state of (bad) health" reveals more to us than the toxic action of agaricus muscaris, which is far too remote and fanciful to be scientific or worthy of respect. It appears the deceased was in a low state of health before he went on his holiday, but from what cause or what his former health was we have no means of determining from the evidence. It is surely a misfortune to see the profession propounding such vague theories with so little to support them, which cannot raise our esteem in the mind of the layman or our real worth in a court of law. Such cases are more fruitful of ridicule than reason, and should be discouraged.

# LETTERS TO THE EDITOR.

# RHEUMATOID ARTHRITIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-Dr. William Murrell's clinical lecture in your issue of this week presents an admirable epitome of the ætiology, pathology, and treatment of rheumatoid arthritis, certainly the best brief statement that I for a long time have encountered. He would add much to the value of his contribution to our knowledge of the therapeutics of chronic phases of the disease if he could follow it with an examination of the values of the various natural hot springs to which so many patients now resort. After observation on the spot at several foreign spas, frequent visits to Aix-les-Bains, and one prolonged stay at Schinznach, I remain very sceptical as to the actual effects of the waters, either as regards their external powers through bathing, or as internal medicines. There is talk about "radioactivity" in these natural hot springs, but is there any scientific evidence of its existence? What I have noticed at these places is temporary abatement of symptoms, due to the warmth of the climate. Aix-les-Bains, for example, in summer is one of the hottest places in Europe; and patients who spend many hours every day basking in the sun in a well-sheltered hotel garden, do undoubtedly gain great relief from pain and discomfort; and this is especially noticeable in those coming from cold and damp climates. If such patients could instead be sent to Egypt or, perhaps preferably, to Algiers, for a winter, would not the ultimate permanent result be better? Dr. Murrell could, no doubt, give a valuable opinion on this point. I have a case now under observation—a lady of middle-age, with slight general chronic arthritis—who is taking iodide of potassium and guaiacol simultaneously, and shows improvement under the treatment. She is living in a southern county on a hillside 300 ft. above the sea, with full south exposure. The subsoil is heavy clay, but this I hold to be no disadvantage at such a height and with resulting good natural drainage. I believe a lower-lying gravel or sand subsoil often determines a more unfavourable local climate than clay on a hill. Perhaps Dr. Murrell could tell us something on this last point.

I am, Sir, yours truly,

A STUDENT OF SIXTY.

Dec. 29th, 1908.

THE NEWSPAPER PRESS AND QUACKERY.

To the Editor of The Medical Press and Circular.

SIR,-Can nothing be done to bring home to the Press the real character of the traffic they are abetting by insertion of the quack advertisements which now occupy so large a space in the majority of newspapers. Up to recent years it has been possible to single out a considerable proportion of newspapers which not only excluded the lowest classes of quack puffs, but also took every occasion to expose fraudulent medical methods of every kind. The number of such papers is rapidly diminishing. Many papers which stand in the very front rank of journalism contain numbers of advertisements which to the eye of the editors, or at least of regular medical contributors to their editorial columns, display the word fraud, so to say, written in big letters across their faces. To-day in a leading London paper I see an enormous and costly puff of a medicine which has been several times denounced as a vile swindle in the High Courts of Justice. regard to some papers to which the proprietors are now admitting advertisements that formerly they would have rejected with scorn, it is evident that the managers are not aware of what the editors are writing, and the editors not aware of what the managers are doing. I enclose a leading article and some advertisements from a paper of the first rank. The article denounces a system of quackery exposed in the Law Courts, and laments the fact that mis-leading advertisements should find admission to respectable papers. The advertisements of this same quackery, which I send with their dates appended, are from this very paper, and, as you will see, these were appearing before and have gone on appearing regularly since the trial. Exactly the same thing occurred in the same paper lately in the matter of a cruel City swindle. This was exposed and denounced editorially in the paper whilst all along it had been advertised in the form of puffs printed next to reading matter in the same journal. Another great paper having lately given place to a series of able and exhaustive articles on "Infantile Mortality," in which the pernicious effects of "baby quieting" medicines were fully discussed, allowed immediately afterwards a long series of puffs of one of these nostrums to appear with a heading in which its value in preventing infantile mortality was set forth. One wonders whether the irony of these transactions may have been completed by the fatal drugging of one of the offspring of the noble owner of the great journal in question. What more likely than that the head nurse in charge of the babies of the house should have relied upon a poisonous narcotic under the belief that it must be "the best thing" since it was advertised in lordship's "paper.

I am, Sir, yours truly,
HENRY SEWILL.

Dec. 29th, 1908.

A WARNING FROM THE MEDICAL DEFENCE UNION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—May I ask, through your columns, medical practitioners who may be applied to for pecuniary or other assistance by a person calling himself "Dr. J. Backus Taylor, M.R.C.S., L.R.C.P.," not to grant any such aid without first communicating with me? Medical agents should also guard themselves in a similar manner before placing the name of this person upon their lists for employment as assistant or locum tentns, and sending them to clients. There is a Dr. Backus Taylor upon the Medical Register, but, from circumstances which have come to my knowledge, it would be as well not to assume that the individual of whom I write is the qualified practitioner of that name in the Register.

I shall be glad to afford any information to anyone applying to me either personally or by letter.

I am, Sir, yours truly,

A. G. BATEMAN,
General Secretary.

4 Trafalgar Square, London, W.C.

AN AFFLICTION HE CANNOT MAKE LIGHT OF-LAMPLIGHTER'S ARM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. Sir,—If the complaint known by the name of lamplighter's arm is caused "by the constant trickling of rain from the pole into his sleeve," what could be easier than have a collar of tin or wood near the hand projecting far enough to protect the sleeve of the lamplighter, something like the flange seen in old pictures of the lace used in tilting to protect the user's hand. Hammer toe, housemaids' knee, tennis elbow, and now lamplighter's arm!

I am, Sir, yours truly,
A. D.

London, W.

# **OBITUARY.**

CHARLES KNOTT, M.R.C.S., M.R.C.P.ED.

We regret to record the death of Dr. Charles
Knott, who for twenty years held the post of
Medical Superintendent to Portsmouth Workhouse
at Southsea. Dr. Knott studied at Guy's Hospital and became qualified as a member of
the Royal College of Surgeons of England in 1872,
and as a member of the Royal College of Physicians
of Edinburgh in 1881. At Portsmouth, for upwards
of 30 years, Dr. Knott held many appointments, chief
among which the following may be noted:—President of the south branch of the British Medical Association, Chairman and Lecturer to the St. John
Ambulance Association and Chief Surgeon to the
Ambulance Brigade, Surgeon-Colonel to the 3rd
Volunteer Battalion (Hants Regiment), Honorary
Surgeon to the Portsmouth Swimming Club, and
Medical Officer of Health for Landport. Dr. Knott
was a Knight of Grace of the Order of St. John of
Jerusalem in England.

# REVIEWS OF BOOKS.

A SHORT PRACTICE OF MIDWIFERY FOR NURSES. (a)

When a book reaches its third edition it is generally very well known, and this fact is sufficient proof of the value of the work, and shows the appreciation with which it has been received amongst that part of the public or profession for which the book was originally compiled. Dr. Jellett has brought the present edition of his book fully up-to-date, particularly

in those parts which deal with the practice of midwifery that have undergone the greatest changes, and to which a large amount of attention has been paid in recent years—the prophylactic treatment of sepsis. As the author says in his opening chapter, "It is no exaggeration to say that the most essential knowledge in midwifery is the knowledge of the meaning and the practice of asepsis." The author describes the methods carried out in the Rotunda Hospital for obtaining this end, and points out the advantages to be derived from the use of rubber gloves, and the necessity for adopting their use is impressed; this is one of the most recent improvements in the technique for obtaining asepsis, and its adoption is to be greatly desired.

The author points out all through his book those cases in which medical aid is to be sent for in accordance with the rules of the Central Midwives Board, and he explains the operative measures which may have to be adopted, not for the nurse to carry them out herself, but so that she may be an efficient assistant to the medical man in the treatment of the patient.

The teaching in Dr. Jellett's book is thoroughly sound, and both simply and clearly expressed. There are few points which may be objected to, and most are matters on which different opinions are held.

The definition given of the first stage of labour is misleading. The full dilatation of the os is the end of the first stage, and although the membranes usually rupture at this time, that phenomenon is not part of the end of the first stage. The definition given tends to promote a very erroneous idea which is commonly held, that because the membranes have ruptured the woman must be in the second stage.

In the management of the first stage the author recommends to allow or induce the patient to walk about. The tendency amongst nurses is often to persist in this, and so to tire out the patient instead of allowing the woman to follow her own instincts.

A short note on cancer of the uterus is added, with the object of enabling nurses to advise women to seek medical advice when they have symptoms which may be due to, say, cancer, and so place themselves in a position to have the condition diagnosed at a time when the disease is still within the scope of surgery and offers a reasonable hope of permanent cure. If nurses will read this note and follow the advice given, the large number of deplorable cases of inoperable cancer which are at present seen will be greatly reduced. The advice in this note is chiefly directed to the removal of some of the most erroneous and widespread popular beliefs about cancer, and the natural course which the onset of the menopause should take in women.

In the appendix are added the Regulations of the Central Midwives Board, and a useful glossary of medical terms.

The third edition of Dr. Jellett's book is a most useful publication, and one which will repay every nurse who obtains it and studies the teaching and advice embodied in it.

THE DUBLIN UNIVERSITY CALENDAR. (a) THE Dublin University Calendar for 1908-9 is presented in the same form as its predecessors of the past few years. It is doubtless a matter of convenience to the student to have in one volume the College regulations and the ordinary examination papers, but graduates of a decade back will regret the banishment to less accessible regions of the lists of graduates who in the past had won distinctions of one kind or another. We look in vain in the present volume for any sign of the great reforms which everyone who knows Trinity College knows to be necessary, if she is to retain her position in the face of the competition that will soon threaten her. The truth is we can hardly expect that the Board, in whose hands is all the power, will either originate or consent to an adequate scheme of reform. To come from great matters to small, we are glad to note that the

<sup>(</sup>a) "A Short Practice of Midwifery for Nurses, as used in the Edunda Hospital, Dublin, for the past ten years." By Henry Jellett, E.A. M.D., F.R.C.P.I., Past Assistant Master Rotunda Hospital, Paird Edition. 453 pages, six plates, and 164 illustrations. London:

<sup>(</sup>a) "The Dublin University Calendar for the year 1908-1909, to which are added the Ordinary Papers set in 1907-1908." Vol. I. Pp. 463. Dublin: Hodges, Figgis & Co. 1908.

College authorities have decided to make it compulsory on junior students attending lectures to live either in College or in residences approved by a committee appointed for the purpose. The sections of the Calendar dealing with the School of Physic contain some inaccuracies, particularly in the lists of the staff of the school and of Sir Patrick Dun's Hospital. We would suggest to those in charge of the Post-Graduate Course that it could be made more attractive by occasional variations in the list of subjects treated. Thus we think that an occasional course in Anæsthetics" would be of interest to the practitioners who constitute the class, while some of the specialities at present in the list might be dropped for a time, and others substituted.

NATURAL THERAPY. (a)
This book is a practical and useful summary of the various kinds of treatment which are conveniently grouped under the heading of "Natural Therapy." We know of no work that covers the same ground, and on that account it makes a convenient manual of reference for the general practitioner or the consultant. In these days of extended and multifarious knowledge, such a companion is absolutely necessary in order to keep abreast of medical progress. The author has divided his subject into six sections as regards the treatment of disease—namely:—(1) The Use of Water. (2) Heat and Light. (3) Massage. (4) Electricity. (5) Diet, and (6) The Modern "Cure." These various sections are then discussed systematically and scientifically, beginning with an interesting historical summary, and proceeding to general principles, the physiological effect on the different systems, and so on. The whole thing is practical, thorough, and scientific. We notice that in thermotherapy, under "dry heat," the author makes a short mention of the Tallerman treatment, introduced in 1893. As a matter of fact, it was introduced considerably before that date, and gave rise to other forms of apparatus, including the "radiant luminous heat." The latter method, introduced, according to the author, by Dowsing in 1896, is held to have "considerable advantages over all other systems." We find nothing adduced to support that statement, and from a close acquaintance with the results of the Tallerman apparatus, we feel convinced that these cannot be surpassed in curable cases. At any rate, the burden of proof lies with those who, while seizing upon the principle of Tallerman's dry heat, add to it light and chemical rays, for which they claim the therapeutic wirtue. Surely the logical plan would be to try the effect of light and chemical rays alone, and compare them with dry heat alone. The X-rays and Finsen light are dismissed shortly. A useful account is given of the rest cure, about which every medical man should be fully informed. Speaking generally, the book will repay careful perusal by all who wish to learn the practical aspects of various physical treatments which nowadays loom so largely on the medica! horizon. The special experience of the author has enabled him to produce a first-rate book. There are 30 plates and 25 illustrations, and the volume is issued in Messrs. Wright's well-known excellency of publication.

THE PROLONGATION OF LIFE. (b) This volume forms the third and enlarged edition of the author's lecture delivered before the Royal College of Physicians on December 3rd, 1903. The keynote to the author's teaching is found in the motto which is inscribed on the title-page, "Work and moderation are the main sources of health, happiness and long life." He maintains that by careful arrangement of the mode of life we may live to go or even 100 years. Even when hereditary tendencies seem to weigh against a person's chances of living long, these tendencies may be altogether overcome by a careful adjustment and regulation of one's habits, food,

dress, and daily exercise. In this edition a short description of the more common articles of food has been added, together with some account of their rôle

in the nutrition of the body.

The author is strongly in favour of regular daily exercise. Walking is the most natural form of exercise. The advantages of walking are numerous, and some of these, as described by the author, we have never seen stated in print before. He has known many persons of advanced life greatly benefited by a daily walk, and remarks that they should always be encouraged to take this, even if they have but re-cently recovered from an illness. Great moderation in flesh food is declared to be necessary if we would live long and healthy lives. Excessive smoking is referred to as a possible cause of arterio-sclerosis, and this, together with the drinking of strong tea in large

quantities, must be condemned.

The book is written in a most interesting and attractive style. It makes one wish to carry out the author's advice in spite of oneself. There is nothing "faddy" "faddy" in any of the statements made by the author. His teaching is dictated by strong commonsense which at once appeals to the reader. The art of living long is by no means easy to follow, but if there is a royal road to its acquirement it will be found to lead along the route so carefully mapped out by the author of this interesting guide. There can be no doubt that many useful lives are prematurely lost to society for lack of due care as to their personal preservation. A study of Sir H. Weber's book will go a long way towards teaching physicians how they must instruct their patients as to the means to be adopted in order to attain to an age beyond the threescore-years-and-ten. The book forms delightful reading, and we consider that its precepts are invaluable to every medical practitioner.

# LITERARY NOTES.

THE third edition of Rawling's "Landmarks and Surface Markings of the Human Body" (H. K. Lewis, 5s. net.) remains of manageable dimensions, the author having resisted the temptation to add anything beyond new illustrations. The illustrations, thirtyone in number, are of special excellence, and justify the popularity that the work has attained. It is a work, indeed, which no practitioner can afford to be without, the need for such a guide making itself felt at each instant in daily practice. It is admirably printed and does credit to the publisher.

THE comely volume of "Memoirs of Dr. Edmund Symes-Thompson," from the pen of his wife, recalls to us an urbane gentleman and accomplished physician, whose death a few months since was sincerely regretted in London medical circles. The late Dr. Symes-Thompson was a man of prodigious and varied activity, whose labours comprised many objects only distantly related to medicine. Profoundly, but not ostentatiously religious, he was an enthusiastic member of the Guild of St. Luke, and organised the annual service at St. Paul's Cathedral, which has since become so popular a festival. He was one of the founders of the Brompton Hospital for Consumption, and was for years the Gresham Lecturer in Medicine. Well may his memory be cherished by those to whom he had endeared himself by a life of consistent kindness and well-doing.

DR. L. F. BARKER'S "Anatomical Terminology" (Churchill, 5s. net) is based on the Basle Anatomical Nomenclature (B.N.A.), which comprises a list of some 4,500 anatomical terms accepted as the most suitable designations for the various parts of the human anatomy visible to the naked eye. One name only is given to each structure, so that the cumber-some mass of synonyms can be swept away. Considering that the total number of terms, including synonyms, exceeds 30,000, it is no small achieve-

<sup>(</sup>a) "Manual of Natural Therapy." By Thomas D. Luke, M.D., F.R.C.8.Edin., formerly Physician at Smedley's Hospital, Matlock, &c., &c. Bristol: John Wright and Sons. 1908. Price 7s. 6d. net. (b) "On Means for the Prolongation of Life." By Sir Hermann Weber, M.D., F.R.C.P., Consulting Physicianto the German Hospital, the National Hospital for Co-sumption, Ventnor, &c., &c. London: John Bale, Sonsand Danielason, Ltd. 1908 Price 4s. £d. net.

ment to have reduced the necessary number of terms to less than 5,000. Most of the terms are those in general use, but some have been selected from anatomical monographs, and a few have been introduced ad hoc. It constitutes a step in advance on the road to anatomical uniformity, though we still have to contend with the use of the vernacular equivalents for the Latin terms in foreign schools. It is to be hoped that authors, at any rate, will, in future, take this list as their guide, thereby earning the gratitude of their readers.

The growing importance of school hygiene is self-evident in these days. The younger members of the profession are finding School Medical Officerships a new field for their energies and ambitions. To such we cordially recommend "School Hygiene," by Robert A Lyster, M.D., Ch.B., B.Sc.Lond., D.P.H., B.Sc. Pub. Health (London: W. B. Clive). It is a handy little guide, and contains everything a school medical officer should know. Of special interest is the new chapter on the Medical Examination of Schools, which has been added in this second edition. The mode of carrying out the instructions laid down by the Education Act, which came into force in the beginning of the past year, is very fully explained. The author is evidently an expert on such matters. The book is well illustrated, and forms an excellent manual in every respect. Although the literature of school hygiene is destined to increase very rapidly in the near future, this small work will be able to hold its own against newcomers, provided the author keeps it within its present limits.

The valuable nature of the Reports of the London Ophthalmic Hospital, edited by Mr. W. Lang, F.R.C.S., is maintained in the present issue. Mr. Nettleship concludes his paper on "Retinitis Pigmentosa and Allied Diseases," which must have been a work of very great labour, considering the material dealt with and the number of generations which were followed out to establish points of heredity. It no doubt will rank as the most masterful contribution on the subject. W. T. Hancock's article on certain points in regard to the "Fields and Fundus Changes in Obstruction of the Central Artery of the Retina" is very interesting. The points he brings forward for attention are (1) The preservation of areas in the temporal field of vision after complete obstruction of the central artery. He has collected notes of 24 cases, besides the two met with in his own practice. As an explanation of the condition, he suggests that the peripheral retina derives nutrition from the choriocapillaris, and that the nasal portion is more functionally active than any other part of the retina. Mr. G. Coots, Curator, contributes a long paper on "Forms of Retinal Disease with Massive Exudation," with several micro-photographic plates, which ought to be read by all ophthalmologists.

### MEDICAL NEWS IN BRIEF.

### Disputed Insanity.

ERNEST GIRARD, a man of education, possessing some imaginary grievance against the British Government, was lately brought up in the South-West London Police Court, on a warrant, charged with assaulting Edward Evans, one of the common-keepers at Putney Heath.

The prisoner, a Swiss, has, in common with members of his family, made himself notorious by a remarkable habit of making Streatham Common his habitation, sieeping out on the common in all weathers. For years he indulged in this practice, using old newspapers as bedding. The family invariably left their litter behind them, and always resented the interference of the common-keepers, on whom fell the responsibility of clearing away the rubbish. They migrated from Streatham to Putney Heath, when the alleged assault took place. A difficulty has arisen, for while Dr. Scott, medical officer

of Brixton Gaol, reported the prisoner as insane, the authorities at Wandsworth Workhouse, to which place the man was sent by order of the Court to be dealt with as a person of unsound mind, dismissed him after detaining him but a few hours. Having in this way secured his liberty, a warrant was granted for his arrest.

Mr. de Grey (the magistrate) expressed his surprise at the action of the workhouse authorities.

Mr. Hanne (for the prosecution): They seem to be of a different opinion from Dr. Scott.

Mr. de Grey said Dr. Scott did not give certificates of insanity readily; he erred on the other side, as a rule. It is difficult to know what to do with the accused.

By direction of the magistrate, Dr. Felix Kempster, the police-surgeon, attended and examined the prisoner, confirming the opinion of Dr. Scott.

Mr. de Grey: You say he ought to be detained in a lunatic asylum?—Yes. He laboured under the hallucination that he is being watched by Government spies.

Mr. de Grey gave directions for the prisoner to be removed to an asylum.

#### Fatal Anæsthesia.

On Saturday last Dr. Danford Thomas held an inquiry concerning the death, in the Central London Throat and Ear Hospital, of a patient aged 23, a carpenter by trade, who had been admitted into the hospital the previous Thursday for the purpose of undergoing a surgical operation for the removal of excrescences at the back of the throat and nose. After the administration of ethyl chloride, the operation was successfully performed, when the patient showed signs of faintness, and expired within ten minutes, although every possible effort was made to restore him. His death was due to syncope whilst he was under the influence of the anæsthetic. Ethyl chloride had not, it was stated, previously proved fatal in any case at the hospital. The jury found that the anæsthetic was duly and properly administered, and that death was the result of misadventure.

An inquest was held at Preston, on the 23rd ult., on Dr. F. T. Walmsley, a councillor of the borough, who was found early that morning lying dead on the floor of his consulting-room, Moss Cottage, Fylde Road. Evidence was given showing that he had had heart trouble, and had been in the habit of taking chloral bromide to induce sleep.

A verdict was returned to the effect that death was due to heart failure, accelerated by an excessive dose of bromide taken by misadventure.

#### Death under an Operation at Burtor.

Death of a Medical Man at Preston.

AT Burton-on-Trent, last week, an inquest was held on the body of an infirmary patient named Samuel Sanders (51), who died while under the influence of chloroform.

The evidence showed that the deceased was suffering from an advanced cancerous growth in the mouth, and that the only hope of preventing an almost immediately fatal issue was an operation. Chloroform was administered by Dr. Ussher, the libuse surgeon, in the presence of two other medical practitioners. The patient suddenly collapsed, and all efforts to restore him proved futile. It was shown that the anæsthetic was carefully and skilfully administered, and that a post-mortem examination revealed an enlarged and diseased heart.

The jury returned a verdict of death from syncope, and expressed the view that the administration of chloroform was properly carried out.

Dr. WM. PORTER, Medical Officer of Portrush, has been presented with a motor bicycle by the inhabitants of the town on the occasion of his marriage, and as a token of their appreciation of his work and of the esteem in which they hold him.

For the purpose of making a presentation to Dr. Fred Wilson, the Medical Officer of Health at Newtown, a meeting of the Urban District Council was specially held on December 23rd.

### NOTICES TO CORRESPONDENTS, &c.

CORRESPONDENCE requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subsoriber," etc. Much confusion will be spared by attention to this rule.

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ONTRIBUTORS are kindly requested to send their communica-tions, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

M.R.C.S., L.R.C.P.Lond.—A usual fee under the circumstances would be three guineas, having regard to the position of the

patient.

B. Samuels.—The book is out of print, but a second-hand copy might be obtained from a bookseller who deals in second-hand medical works.

DB. MAJENOIE (Paris).—No such preparation is referred to in the British Pharmacopeia (last edition), and we regret that, on inquiry, we are unable to give our correspondent the information he seeks.

### THE MODERN OVER-CULTURE OF CHILDREN.

THE MODERN OVER-CULTURE OF CHILDREN.

A TIMELY article in the January number of the Girl's Own Paper and Woman's Mayasins denounces, in no uncertain manner, the tendency of the modern mother to over-educate and over-develop young children at the age when the brain cannot stand the strain. With regard to the growing acquaintance of the child with his environment, it is a rafe rule to abstain from incessantly volunteering information. It is, says the writer, a terrible mistake to do as we have seen specially conscientious mothers do—constantly stimulate a little brain by offering jucid explanations, and everlastingly jointing out this, that, and the other, "taking pains" with him to an extent which would be heroically unselfash if it were not so utterly deluded and unnecessary. Is he playing at home? she must be at his elbow with suggestions—helping, guiding, prompting arranging—every moment. All this tugging at a growing brain is injurious." It is far kinder to keep a watchful oye on the child, leaving him to his own devices for amusement.

Vaccunst.—There is nothing specific in the "Leicester Method";

VACCINIST.—There is nothing specific in the "Leicoster Method"; indeed, we do not think that it was ever claimed to be. The method consists in an attempt to control small-pox outbreaks by disinfection, isolation, and the vaccination of contacts, without relying on universal compulsory vaccination. The experiment is a pretty one, and should be watched with interest. It is not often that a community will consent to sacrifice itself pro bono publico. This Leicoster, consciously or unconsciously, is doing, and their experience, so far, has not disappointed adherents to their dectrine. their doctrine.

STAMMER.—It is not necessary to send the child to a special school or teacher, if the mother is intelligent, sympathetic, and persevering. The great things are to regulate the breathing and to inspire confidence. Long breaths should be taken and consciously controlled, while the words, or rather syllables, are deliberately and slowly pronounced in a definite, organised manner. Keenness in the teacher also acts in inspiring confidence in the child.

DISTRAIN.—We cannot waste much sympathy on the gentleman ourselves. He clearly understood the position and declined to take any reasonable precaution. The case is a sad one, but hardly, we think, deserving of a special appeal, especially as he is not a medical man.

SCHOOL-BOY "HOWLERS."

SCHOOL-BOY "HOWLERS."

Our contemporary, the University Correspondent, has published some amusing "howlers" by schoolboys, of which we give a selection below:—

"Lumbago is a mineral for making lead-pencils."

"A the mometter is a short glass tube which regulates the weather."

weather.' The chief lakes of England are Ullswater, Derwentwater,

"John Bright is famous for an incurable disease."
"Ueen Elizabeth's face was thin and pale, but she was a stout Protestant."

"If care is not taken with dusty corners, microscopes will breed there."
"Things which are equal to other things are equal to one

mounter.
"Chivalry is when you feel cold."

HEYS SAW.—We should advise you not to go in for appointment. The minimum salary that should be offered

£250 a year (and that is little enough), together with all out-of-pocket expenses. Any man taking less is acting as a cut-throat in the competition, and makes it more difficult for his fellows

to obtain a fair wage. £150 a year is preposterous.

CHARTER.—The subject is hardly one for discussion in our columns. You should form your own views on it after reading the abundant literature on the matter. We agree. Chartered companies have a knack of being taken overby the Government.

### Meetings of the Societies, Tectures, &c.

TRUBBDAT, JANUARY 7TH.

RONTOEN SOCIETY (20, Hanover Square, W).—8.15 p.m.: Mr. C. E. S. Phillips: A Description of Three Sub-standards of Radio-activity recently prepared for the Rontgen Society (these Specimens will be exhibited). Mr. H. C. Head: A new Localising Apparatus designed by Staff-Surgeon Dr. Gillett.

NORTH-EAST LONDON CLINICAL SOCIETY (Prince of Wales's Hospital, Tottenham, N.—4.15 p.m.: Dr. De H. Hall: Hemorrhage from the Stomach, its Cause and Treatment.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SEIN (Leicester Square, W.C.).—6 p.m.: Othersfield Lecture: Bullous and Vesicular Eruptions: I., Urticara; II., Pemphigus, III. Pompholyx; IV., Varicella.

FRIDAY. JANUARY Sew

IV., Varicella.

FRIDAY, JANUARY STH.

BOYAL SOCIETY OF MEDICINE (LAETHOOLOGICAL SECTION) (20, Hanover Square, W).—5 p.m.: Discussion: A Discussion will be held "On the Modern Treatment of Syphilis, especially in regard to the Upper Respiratory Passages." The Discussion will be opened by Dr. Lieven, of Aix-la-Chapelle. Fellows and Members who wish to take part in the Discussion are requested to send their names as soon as possible to Dr. Cathcart, 35, Harley-Street, W.

ROYAL SOURCE OF MEMORIPA (C. M.)

Street, W. ROYAL SOCIETY OF MEDICINE (CLINICAL SECTION) (20, Hanover Square, W.).—8.30 p.m.: Dr. James Mackenzie: Demonstration of the Methods for Taking and Interpreting Graphic Records of the Movements of the Circulation. Dr. J. Mackenzie and Dr. T. Lewis will also take Tracings from Two Patients.

### Appointments.

CROOM, D. H., M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Edinburgh District of the county of Edinburgh.

DAYIE, J. A., M.B., M.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Forgue District of the county of Aberdeen.

MAY, OTTO, M.B., B.C.Cantab., M.R.C.P.Lond., Medical Registrar to Middlesex Hospital.

OLIVER, W. GRANT, L.D.S.Eng., Dental Surgeon to the Royal, Naval Hospital, Plymouth.

PATTERSON, NORMAN, M.B., B.Ch.Edin., F.R.C.S.Eng., Assistant Surgeon to the Golden Square Hospital for Diseases of the Throat.

Throat.

REARDON, J. C. P., L.B.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Kinghorn District of the county of Fife.

SHAW, C. J., M.D.Edin., L.R.C.P.Edin., Medical Superintendent at the Arygle and Bute District Asylum, Loohgilphead.

TALLOR, FRANK E., M.D., F.R.C.S., Obstetrical Registrar to Middlesex Hospital.

### Pacancies.

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Rotherham Hospital and Dispensary.—Senior House Surgeon. Salary, £110 per annum, with rooms, commons, and washing. Applications to the Secretary, H. Helson, Masonic Buildings, High Streef, Rotherham.

London Fever Hospital, Liverpool Road, N.—Assistant Resident

High Street, Rothernam.

London Fever Hospital, Liverpool Road, N.—Assistant Resident
Medical Officer. Salary, £150 per annum, with residence and
board. Applications to the Secretary

### Births.

Howett. - On Jan. 2nd. at 53 Queen Anne Street, London, the wife of C. M. Hinds Howell, M.D., of a son.

### Beaths.

SMITH.—On Jan. 1st, at 173, Blythe Road, West Kenaington, Sidney Smith, M.D., M.R.C.S., late of Bombay, in his 74th year.
WOAKES.—On Jan. 2, at Belvoir House, Farcham, Rebecca Liveing, wife of Edward Woakes, M.D., late of 78, Harley Street, London, eldest daughter of the late Charles Shepheard, Esq., J.P., of Ealing, aged 68.



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B. M. J., August 15, 1908, pages 391-394

Medical Press, November 4, 1908, page 494;

November 11, 1908, page 527

Lancet, December 5, 1908, pages 1656-1658

SLEEPING

Quarterly Report on the Progress of Segregation Camps and Medical Treatment of Sleeping
Sickness in Uganda, ending February, 1908,
pages 27, 28 and 29

KALA-AZAR Lancet, November 21, 1908, pages 1527-1528

CANCÉR

B. M. J., December 19, 1908, page 1845

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## THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, JANUARY 13, 1909.

No. 2.

### Notes and Comments.

Under which King?

THE Derbyshire Education Committee have embarked on a new and dangerous policy, to which the attention of the profession should be

directed. It seems that the attendance in the Council's schools has been bad, owing to the ill-health of the pupils, and the Committee have decided on insisting that every medical man who grants a certificate of unfitness to a child shall be in attendance to give evidence at the police court when the parent is summoned for the child's absence. Further by way of greasing the attendance machinery, it appears that they have been sending their school medical officer to patients certified by private practitioners to be unfit for school attendance, and in some cases, at any rate, over-ruling the medical attendant's decision. We find it difficult adequately to express our opinion of these procedures. A family have a perfect right to be guided in the withholding of their child from school by the advice of their own doctor, without any arbitrary interference by the education authority, and it is nothing less than an insult to medical men for the authority to refuse to accept their certificates. Moreover, if a medical officer, usually a younger. and less experienced man, is sent round to revise the decision of such practitioners, a most unseemly position is created, especially if he sees them without consultation with the family attendant. If the ·Committee wish to retain in their own hands the power of deciding which children are fit to attend school, presumably they might, without particular offence, accept only the certificate of their own officer, and make it part of his duties to certify all such cases. But to browbeat and over-ride the family medical attendants by the present methods is preposterous, and we hope that a collective protest may be made in the interest of the dignity and responsibility of the profession.

THE appointment of a bacteriologist A Royal
Bacteriologist.

His Majesty's Household is a welcome sign of the times, and we congratulate Dr. Harold Spitta on being the first converse of the being the first occupant of the new

post. The recognition by the King that bacteriology is so practical a science that he needs an officer of his own to practise it, shows that not only is His Majesty abreast of modern scientific opinion, but that he has greater understanding of, and appreciation for, hygiene than some of his forbears. It is not fifty years since Windsor Castle was discovered to be founded on ancient cess-pools, which must have poisoned long lines of Royal attachés, but, unhappily, were only brought to light when they had slain the Prince Consort, and nearly succeeded in killing the Prince of Wales. Fortunately, the Royal Family and their "dine and sleep" guests are now provided with less sewer-gas than in the good days of old, but in some of the ancient palaces we should old, but in some of the ancient paraces we should not be surprised if there were not an interesting field for bacteriological research. The educative value of the King's example in the matter of the appointment of a bacteriologist cannot but be great, for people will argue that even if the occupant of the post is not so dignified a person as a groom of the chamber or a page-in-waiting, at least he would not have been appointed if bacteriology were not a science having already a very practical bearing on the everyday affairs of life.

Conjunctiva.

THE latest piece of quack-booming From Colliery comes from Scotland, where one to William Miller is extolled as an "eye-doctor" of marvellous powers. Like the bone-setter Rae, this pre-

tentious individual is a miner by trade, and if there is any excuse for becoming a quack, we think, perhaps, the prospect of earning a living above ground, instead of in the bowels of the earth, is the most plausible. To this degree of affluence Miller seems not to have attained, but, thanks to the publicity being given to him, no doubt he will in time. As it is stated that fifty to sixty patients, drawn from the upper classes of the neighbourhood, visit him on Saturdays and Sundays, it is difficult to see why he cannot make a very comfortable living; a good many medical men would be satisfied with that number a week, even if they only paid half-a-guinea a head. When we come to Miller's claims as to treatment, we confess to having less patience with him, for he holds out to cure cataract, ulceration, "dirt tumours," "fire," and "that ungainly inflammation so often the residue of measles." Without pretending to know what fire and dirt tumours are, we may safely say that any unqualified man who holds himself out to cure this list of diseases should be amenable to the criminal law, as the suffering which unskilful and unin-structed "treatment" may cause in the eye is conceivable only by those who have experienced it.

Sea-sick to Order.

THE man, be he medical or lay, who discovers a real preventive of seasickness, of a harmless character, and of universal application, will deserve, and probably make, a for-

tune. In the meanwhile, there are many dabblers, and sea-sickness cures are usually the most evanesscent, of all quack remedies. If every charlatan could only be induced to run one the trade would soon be bankrupt, for however much pleased one or two people may be with the apparent results of a "cure," the bulk of suffering humanity cannot be persuaded that the charm is working to perfection when they

spend most of the voyage pensively leaning over the ship's side. Sea-sickness is often spoken of as a typical neurosis, and it is not a bad thing for some of those who have no sympathy with neurotics to feel the irresistible qualms of this particular variety, for it is a neurosis of an uncommonly real character. It is just reported from Boston that the Allan liner Carthagenian has arrived there after a stormy passage, carrying fifty-seven saloon passengers, who were hypnotised by the surgeon, and that not one of them was at all affected by the movements of the steamer. Credat Judæus. So far we have only telegraphic reports from the city of culture and romance; when the passengers themselves come back we should like a few minutes' conversation with them. Some may have felt benefit from the system; but we cannot be persuaded that not one out of fifty-seven escaped without a qualm.

### LEADING ARTICLES.

### THE REPORT UPON THE INEBRIATES' ACTS.

[FIRST NOTICE.]

It would be difficult to name any social reform in which the medical profession is closely interested of greater importance than that which deals with alcoholism in its many phases. Every legislative effort to deal with the habit certainly deserves our close and sympathetic attention. The recent publication of the report of the Departmental Committee is, therefore, a matter of considerable interest, and we propose to deal with that document at some length. Some of our readers will doubtless recall the terms of the Reference of April 24th, 1908, whereby the Committee were directed "to inquire into the operations of the law relating to inebriates, and to their detention in reformatories and retreats, and to report what amendments to the law and its administration are desirable." On August 17th, in the same year, this was supplemented by an authorisation "to investigate the value of existing methods for the treatment of inebriety by the use of drugs." With regard to this second reference, it may be noted that the manner in which it was interpreted by the Committee, and the impracticable nature of such an investigation, render it of little value. The verdict of the medical profession is the only one likely to be sound and final upon the subject, and no single one of many vaunted "cures" has so far withstood the test of scientific investigation. The Committee have not investigated the methods of treatment by drugs with respect to their efficacy or comparative merits. They merely set themselves to ascertain whether these methods could possibly be used as an alternative to detention, and they report that, quite irrespective of their merits, it would be impracticable to enforce by Act of Parliament any specific mode of medical treatment. The Committee deprecates any further inquiry into the matter, as likely to establish an objectionable precedent; and with this opinion we entirely agree. Turning to the Report itself we find in the introduction a feature that is unique in such a document, namely, a broad and philosophical introduction to the whole subject. After a long experience of such papers, we can safely say, never within our recollection has a Report of the kind been distinguished by so valuable a preface. The plan adopted throughout the Report is to graduate the measures recommended for dealing

with inebriates. In this way it is easy to follow the transition from the mildest methods likely to be of service up to those of the most stringent nature, as may be required to fit the case of the individual inebriate. Two new features of the recommendations deserve close attention. The first is a statutory pledge, breach of which is to form a ground for the application of compulsory control. The second is to institute a guardianship, whereby an inebriate can be controlled without being kept in a retreat; such guardianship may be either voluntarily sought or compulsorily imposed, the latter being the more stringent. Both suggestions appear excellent, inasmuch as they present reasonable alternatives to that summary interference with the liberty of the subject which is apt to be resented by our countrymen. When all these various methods have been tried and found insufficient, it is recommended that the inebriate be sent compulsorily to the retreat. One salient fact brought out by the Report is the failure of the Inebriates' Act, 1898, and the reasons of that untoward result have been carefully investigated. The opinion is expressed that it should be as easy for a magistrate to commit to a reformatory as to a prison, and that the difficulties in the way of such a course should be abolished. These difficulties may be thus briefly summarised and dealt with as follows: -(1) The definition, at present defective, should be replaced by a new one. (2) As to the "three previous convictions," the Committee advise that the present necessity of proving them be abolished. (3) With regard to the refusal of the offender to be dealt with summarily, it is recommended that he should in future be deprived of that option. (4) The abolition of the three years' sentence is advocated, with the substitution of a system of sentences graduated in length according to the repetition of the offence. The Committee further recommend that advantage should be taken of the Probation of Offenders Act by liberating offenders against the Inebriates Act on probation, with or without previous sentence to a reformatory, breach of the conditions of probation being met by a return to the reformatory. Finally, a chapter is devoted to the discussion of the proper authority to be entrusted with the provision of reformatories and the maintenance of inebriates therein, and the extremely important conclusion arrived at is that these functions should be performed by the State, and not by the local authorities. It will be evident to the reader that the tendency of the whole Report is to assume a more thorough control of the inebriates in the interests of the community. deliberate opinion of the Committee is that, in pursuance of that end, the compulsory detention of inebriates is justifiable apart from all question of reformation. In the application of this general principle they have not hesitated to accept its final application to the extent of advising that the detention of irreformable inebriates should be practically permanent. Every inebriate, however, even of the worst and most irreformable character, is to be liberated on probation at the end of three years, subject to a speedy return to detention for another three years if he fails to conform to the conditions of his probation. This is in practice almost an indeterminate sentence, but it is free from the objections to that measure which were pressed on the Home Secretary when the Prisons Bill was before the House of Commons. In conclusion, a word of congratulation may be offered to the Committee on the admirable literary style with which they have

clothed a report dealing with an enormous mass of important facts and considerations.

### CURRENT TOPICS.

#### The Indian Medical Congress.

A good deal of interest is attached to the forthcoming Medical Congress which is to take place in Bombay on February 22nd and the four following days. The subjects set forth for discussion are concerned, for the most part, directly with tropical diseases. Among well-known authorities who have signified their intention of being personally present are Professors Ronald Ross, Kitasato and Musgrave, Colonel Semple, Majors Donovan, Lamb, Smith, and Leonard Rogers, Captains Greig, Forster, Christophers, and Dr. Fowler; whilst others, including Sir Patrick Manson, Sir Lauder Brunton, Colonel MacLeod, Professor Osler, Drs. Nash, Niven, and Ashburton Thomson, will submit papers if they are unable to attend personally. His Excellency the Governor will preside at the meeting, and it is significant of the modern official attitude with regard to medical science that the inception of the scheme came from Government House. The list of Vice-Presidents and of others specially connected with the Congress naturally includes a large majority of Army medical officers. This fact doubtless registers the new era that has sprung up amongst the present generation of medical men in India. There is still a large field open to scientific investigation in tropical diseases, while that of prevention and of sanitary administration is practically boundless. It is to be hoped that the new scientific leaven will permeate all classes and ranks of medical men, whether civilian or military. As regards young India, with its modern claims to increased powers of self-government, there could be no nobler and finer field than that of carrying the Western gospel of sanitation into the houses of their countrymen. There are excellent Indian medical schools, and it is possible for Indians to obtain a professional education without going to the expense of a special training in one of the British centres. The proccedings of the Bombay Congress will be followed carefully by our numerous readers who are interested in the subject of tropical medicine.

Old-Age Pensions and the Senile Heart

ONE of the immediate results of the institution of the Old Age Pensions on January 1st of the present year has a good deal of medical interest. A number of deaths have been reported of aged persons who were entitled to draw their first pension money on that date. Some of these fatalities took place on the night preceding the necessary visit to the post office, some on the morning of the appointed day, and more than one at the office itself. The cause of these pathetic occurrences is not farto seek. The senile heart, under ordinary circumstances, has little reserve power to fall back upon to meet any extra strain that may be thrown upon it. Arteries become thick, and the heart gradually settles down to its routine work, which is kept at a minimum by the natural disinclination of old age to any but the slightest physical exertion. This remark obviously does not apply to the exceptional

aged person whose arteries are healthy and who engages in active exercise, and, it may be, also occupation, until well into a second century of years. Such persons would bear the excitement connected with a pension, or other exceptional mental or physical strain, without damage to their cardiac competency. The difference between robust old age and senile old age could hardly be better illustrated than in the tragedies connected with the first day of pensions for the aged poor. The moral of the matter is clearly that it would be wiser for old folk to get medical advice as to the state of their circulatory apparatus before subjecting themselves to any unnecessary or undesirable strain in connection with their pensions. Further, it would be well for the Government to make the way smooth for all who are shown to be compelled to make their application in person.

Poisoning by Barium Sulphide.

THE use of barium sulphide as a poison must be rare indeed, but an undoubted case was brought to light at a coroner's inquest in Dublin on January and. A woman of intemperate habits, who had suffered from delirium tremens and was frequently depressed in mind, was heard one day to fall on the floor. Her husband and step-daughter ran up to her, and, suspecting poison because of various threats she had made, sent promptly off for a medical man, who seems to have been immediately on the spot. The usual remedies were applied, but without effect, and death took place in a few hours, the patient not being unconscious for some little time. She herself said she had taken poison, and indicated as the agent a bottle of cosmetic fluid, which turned out to contain barium sulphide-this substance being used as a depilatory. Although no analysis of the stomach contents was made, there was no doubt that this salt, and not alcohol, was the operative cause of death. Post-mortem, the brain and lungs were found to be much congested and the heart small and fatty; no very distinctive signs, however, were discovered. This case, interesting as it is from the rarity of the agent used, illustrates the danger which attends the unregulated sale of even apparently harmless hair-washes and similar compounds used for cosmetic and domestic purposes.

Dirty Railway Carriages.

In our last issue we drew attention to the improper heating and ventilation of railway carriages at this season of the year. It is not only in these matters, however, that our railway system leaves much to be desired from the point of view of health. The seats, walls, and floors of the carriages, more particularly third-class carriages, are usually dirty in the extreme. On the main lines, and on express trains, there is some pretence to cleanliness, but on branch lines and the less important trains the condition of the carriages is usually revolting. In third-class carriages spitting is freely indulged in, and apparently-beyond posting useless notices—the companies and their officials take no steps to abate the nuisance. Complaints from passengers are treated with indifference or insolence. The carriages rarely appear to be cleansed. We drew attention to this matter some time ago, in the hope that evidence relating

thereto might have been put before the Royal Commission inquiring into Irish railways, but none of the societies concerned with sanitary affairs in Ireland moved, and it was left to a Commercial Travellers' Association to take the matter up. We do not know whether local sanitary authorities have any power to enforce greater cleanliness in railway carriages, but there is no doubt that the scandal will soon go beyond endurance. As far as Ireland is concerned, we would commend the consideration of this subject to the Women's National Health Association, which has shown so much activity in other directions.

### The Poisons Act.

THE Poisons and Pharmacy Act, which found its way to the Statute Book in the closing days of the autumn session of Parliament, puts a stop, for some time, at least, to a long-standing quarrel between the pharmaceutical chemists of the country and the companies owning drug-shops. It is some years since the House of Lords decided that corporate bodies were outside the penal clauses of the Pharmacy Act of 1868. Since that decision we have had the curious anomaly that, whereas pharmaceutical chemists were tied up by certain legal restrictions, companies could keep drug-stores and deal in drugs without let or hindrance, and without even a single qualified pharmaceutical chemist in their employ. By the new Poisons Act it will be necessary for companies to employ a qualified chemist as manager, and if the company carries on its business in more than one set of premises, then a qualified man must be manager in each. This is a great advance on previous conditions, and though not as radical a reform as some desired, it gives both the public and the pharmaceutical craft further protection. Certain changes in the schedules of poisons are also made by the Act.

### Medical Certificates of Character.

A curious case, which is of interest to medical men generally, was heard at the end of last month at the Westminster Police Court. Dr. F. K. Marsh, of Bradford, was charged with the offence of knowingly aiding a midwife of the name of Inglis to secure unlawfully and fraudulently a certificate of admission to the Midwives' Roll. It appears that Dr. Marsh, who has been in practice in Bradford for many years and possesses a very high reputation there, gave a certificate to this woman that she had been in bond fide practice as a midwife since 1885, and was trustworthy, sober, and of good moral character. As a result of this certificate she was placed upon the Roll, and remained there until 1908, when a report was made to the Central Midwives Board that she had been guilty of negligence and misconduct in the exercise of her calling. Inquiries were then made, and it was found that she had been tried at the Leeds Assizes for murder, on the ground that she had killed a woman by performing an illegal operation. She was convicted of manslaughter and sentenced to three years' penal servitude. It was quite evident that Dr. Marsh gave the certificate in good faith, and, after hearing the evidence, the magistrate dismissed the case against him, but did not acquit him of carelessness. It is essential that medical men should exercise the very greatest care in the giving

of testimonials to assure themselves that the recipients of them are suitable persons. There is no doubt that, either out of excessive good-nature, or, as in this case, from insufficient knowledge of the recipient, certificates are at times given to women who are entirely unworthy to enable them to get positions, or to induce hospital nursing committees to admit them as probationers. The medical profession suffers for this as a body, and, in its own interests, it should set its face against the practice.

Radiography in Non-Medical Hands.

THE medical profession of Paris has been recently exercised by the question as to whether the practice of radiography should be carried on by nonmedical operators. At the request of the French Government the matter has been referred to a Committee of the Academy of Science. As the ill-effects of the rays are manifested upon the human body in a way common to many traumatisms, it will seem to most medical men that such injuries would fall naturally within the province of the medical art to detect, to diagnose, and to treat. Yet for some inscrutable reason practical radiography is to this day left in the hands of non-medical assistants in some of our leading British hospitals. There is some excuse for this practice in remote country places, and also, perhaps, when the radiography is conducted under the close personal supervision of a medical man. As a general rule it is most desirable for any radiographic examination or treatment to be carried out by a medical man, who is trained to recognise the faintest sign of danger, and is charged with a full sense of his moral and legal responsibility. Were the Medical Acts interpreted in favour of the protection of the safety of the public, the responsibility for any mishap that would be cast upon the lay operator would speedily crowd him out of existence. The question is one of some importance to the medical profession, who cannot afford to let much more of their legitimate work drift into outside hands unless they are prepared to find their occupation gone.

The Credulity of Superstition.

THE following passage occurs in a leading article on "Credulity and Superstition" in the Times of the oth inst. :- "The advertisement columns of any provincial newspaper, and of not a few journals of higher repute, show how readily people swallow, with this or that quack medicine, the most incredible tales of its supposed power to cure by a few doses some conglomeration of ailments that has defied doctors for years." We have not examined the advertisement columns of the Times of the oth, but we could easily produce a considerable number of samples selected from a large assortment which exactly answer the description of those objected to in this leader. Two of such have appeared within the last few weeks. Each of these is printed in a conspicuous position next to important reading matter. They vaunt the powers of two medicines which between them profess to cure some forty distinct ailments, including constipation, bladder, kidney and brain diseases, indigestion, insomnia, and mental derangement. Some time ago the Times published a leader dealing with a case in the Courts, and lamenting "that the advertisement sheets of certain publications are continually made

the vehicles of statements which can only be described as preposterous, and frequently as being false to the knowledge of those that make them. It is almost incredible, but nevertheless a fact, that the advertisements alluded to had been appearing all along in the Times, and have since been continued up to now. It is evident that the editors are not aware of what the managers are doing, and the managers are not cognisant of what the editors are writing. It is impossible to believe that the chief proprietors of the Times, whose name stands for all that is fastidiously honourable in journalism, can be aware that, owing to some unfortunate lapse in supervision, their great paper is laying itself thus open to criticism. The Times forms the criterion of journalism. The smallest lapse in its conduct encourages many other inferior papers to "go one worse." In several second in position only to the Times there have lately been appearing enormous and costly puffs of a nostrum denounced more than once in the High Court as a vile imposture. The vast amount of suffering and misery endured by the credulous masses through reliance upon worthless nostrums should be known to the asute editors and men of the world who direct the newspapers. The whole story of cynical quackery has been completely unfolded in the law reports in their own pages, and has been constantly set forth forcibly in all the medical journals, and it is impossible to guess how papers that set themselves up as censors of morals and guardians of the welfare of the people can justify their conduct in carelessly or knowingly abetting a traffic not only fraudulent but cruel to the last degree.

### PERSONAL.

THE QUEEN has given a donation of £1,000 to be expended in the purchase of extra-regulation articles, which will add to the comfort and convenience of sick soldiers in military hospitals at home stations nursed by Queen Alexandra's Imperial Military Nursing Service.

YESTERDAY, Princess Louise Duchess of Argyll attended a matinée of children's plays in aid of the Prince of Wales's General Hospital, Tottenham, and the Kensington District Nursing Association, at the Theatre Royal, Haymarket.

Dr. Marnan, Senior Assistant Medical Officer at Bristol Lunatic Asylum, has been appointed Medical Officer of the like institution at Gloucester.

Ex-President Castro has undergone an operation in the private hospital of Professor Israel, to which he returned from his hotel on January 2nd.

Dr. ALEXANDER ROBB, Medical Officer of Paisley, has been appointed Medical Officer for the Counties of Midlothian and Linlithgow vice Dr. Brock deceased.

Mr. BLAND-SUTTON will deliver the second lecture of the Hunterian Society to-night. His subject is the "Occurrence of Thrombosis and Embolism after Operation on the Female Pelvic Organs."

THE name of Surgeon-General Sir Charles Cuffe, K.C.B., Army Medical Staff (retired), has been placed on the Commission of Peace for the County of London.

THE City of London Lying-in Hospital has received £2,000 from the executors of the late Mrs. A. A. Chippendall Higgin.

DR. LOUIS C. PARKES will deliver the Chadwick Lectures on "The Medical Aspects of Recent Advances in Hygiene as Connected with Sewering," at University College, London, beginning on February 2nd.

THE following gentlemen have been appointed to the Registrarships at the Middlesex Hospital:—Medical, Dr. Otto May, M.R.C.P.Lond.; Surgical, Mr. Cecil W. Rowntree, F.R.C.S.; and Obstetrical, Dr. Frank E. Taylor, F.R.C.S.

THE annual dinner of the West London Medico-Chirurgical Society will take place at the Wharncliffe Rooms, Great Central Hotel, on Friday, February 12th, at 7.30 for 8 p.m. punctually.

At the annual meeting of the League of Mercy, it was announced that a cheque for £19,000 has been handed over to the King Edward's Hospital Fund for London by the League.

THE Essex Parliamentary Committee has approved of an increase of salary from £700 to £800 per annum of Dr. Ambrose, Coroner for the Metropolitan District, as from January 1st last.

THE will of Sir Alfred Pitman, M.D., F.R.C.P., Emeritus Registrar of the Royal College of Physicians of London, who recently died at the patriarchal age of 100 years, was proved last week in the Court of Probate at £10,267.

We are glad to learn that the omission of a medical man from the Midwives Act Committee recently appointed, has been rectified by the inclusion of Mr. F. E. Freemantle, Medical Officer of Health for the County of Hertford.

THE name of Colonel P. M. Ellis has been officially gazetted, to be Surgeon-General, Army Medical Service, vice Surg.-Gen. W. B. Slaughter, retired. Lieut.-Col. R. Jennings, M.D., will succeed to the post vacated by Col. Ellis.

THE late Mr. Harry Barnato's will confirms the report previously published that £250,000 had been bequeathed to "build, equip, and endow a home, hospital, or other charitable institution," in memory of his brother, Barney Barnato, and his nephew, Woolf Joel.

WE offer sincere congratulations to our confrère. Sir James Barr, M.D., of Liverpool, on his rescue last week from a perilous position in the Swiss Alps, where, with his son, he had lost his way in attempting to climb the Niederhorn. The son is suffering, unfortunately, from frostbite.

A CONFERENCE on Tuberculosis will be held at Caxton Hall, Westminster, on February 16th to 19th. Among the patrons are the Duchess of Norfolk, the Duchess of Sutherland, Lord Carrington, the Bishop of London, the Lord Chief Justice, Lord Cross, and Lord Barnard.

THE annual meeting of the Association of Public School Science Masters was held yesterday at Merchant Taylors' School, Charterhouse Square. An address on the relation of general to technical science teaching was given by the President (Sir Clifford Allbutt, K.C.B., M.D.), and Mr. M. D. Hill read a paper on "Anthropometry in Schools."

### A CLINICAL LECTURE

### PNEUMONIA IN THE AGED.

By PROF. R. RIMBAUD, M.D.,

Director of the Clinique at the Faculty of Montpellier.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

THE salient features of pneumonia in the aged are, on the one hand, its gravity and, on the other, its insidiousness, so that it is not without good reason that Grisolle warns us that "we must never forget that in the aged the gravest lesions may be manifested only by a few slight, almost insignificant, symptoms."

With regard to its ætiology this form of pneumonia is associated with the presence of the pneumococcus which, as was shown by Courmont, of Lyons, is commonly present on the tonsils where it leads a saprophytic existence. It is found in the sputum, in the pulmonary exudation, in the pleura, in the pericardium, sometimes even in the meninges. It is readily inoculable in the mouse, and it may be detected on the soiled

garments and linen of the patients.

The contagiousness of pneumonia cannot be questioned, for in hospital wards it is often transmitted from one bed to the next, and indisputable epidemics have been observed in certain asylums for the aged. At the same time its contagiousness is not as pronounced as that of the eruptive Among accidental causes the aged are particularly susceptible to cold, and it is noteworthy that of 156 cases of pneumonia Hourmann and Dechambre met with 109 between December and March. It is sometimes due to traumatism, but this is rare in the aged. Inspiration of dust and irritating vapours has also been incriminated.

Old people obliged to remain in bed owing to paralysis, urinary troubles or injury, are apt to develop pneumonia, though usually of the hypostatic form, but such a patient, if exposed to cold or to pneumonic infection, may develop true pneumonia, and then most frequently on the

right side.

The lungs of the aged, moreover, are more vulnerable than those of the adult. They often suffer from bronchitis and pulmonary congestion, then, too, the rigidity of the thorax hinders proper aeration and favours stasis of the blood, the enfeeblement of the heart and pulmonary emphysema also contribute their part, and with advancing years there is a general decline in the resistance to infective agents. Age is not the only measure of senility, however, for our age is that of our arteries, so that an alcoholic, plumbic or atheromatous subject may be more liable to an attack than one far older, but in better physiological condition.

Pneumonia seems to attack the aged of both sexes indifferently, and the liability increases pari passu with years, and so does the case

mortality.

Pneumonia in the aged presents a rather special symptomatology, but the attack may be characterised by the same symptoms and run the same course as in the adult. As Professor Lemoine observes, there are persons who remain young in spite of sixty years or more, clinically speaking; their respiratory and circulatory apparatus have remained in good state and the brain is clear. In fact, they are virtually adults, and in them pneumonia runs the same course as in the young

As a general rule, however, these symptoms are conspicuous by their absence, there is simply headache, vomiting and more or less pronounced prostration. The initial shivering is often wanting, and in any case is never as marked as in the adult. At most there may be now and again slight feeling of cold, such as is met with in association with pleurisy in the adult. The same may be said of the pain in the side. It is often absent, and when the patient does complain of pain it is usually referred to the pit of the stomach. Dyspnæa. may be quite inconspicuous in the elderly patient, especially in left-sided pneumonia, and this is the more remarkable seeing that we are dealing with emphysematous, cardiac or renal subjects who suffer more or less from dyspnæa in connection with their previously existing malady. Then, too, there is often little or no cough, or, if present, it is moderate, short and dry.

. We must not rely on rusty expectoration in the aged, for many of these subjects neither cough. nor spit and, curiously enough, this is specially the case in grave attacks. Such expectoration as there is is white and stringy, sometimes yellow and streaked with blood. In aged patients the sputum is often greenish in colour, and this seems to be characteristic of pneumonia of the aged. Microscopical examination, however, reveals the existence of the pneumococcus, and shows the sputum to be made up of a mixture of mucus and albuminous exudation with endo-

thelial cells which stamp the diagnosis.

The physical signs are extremely important. While in the adult percussion yields a dull note over the pulmonary lesion, this may be absent in the aged, and may even be replaced by tympanism due to pre-existing emphysema or bronchial dilatation. On auscultation the crepitant rale, often very short-lived in the adult, may be wanting or escape observation, simply because the subject at this stage does not as yet present local or constitutional symptoms which suggest auscultation, so that he often does not come under medical observation at all during the initial stage. By reason of the concomitant bronchitis too the rales are much moister, more like mucous or sub-crepitant rales. breathing is often the first sign to be perceived, but in the aged it is, as a rule, less extensive, more circumscribed than in the adult. also be intermittent, coming and going with great rapidity. These variations are due to the feebleness of respiration, or to the presence of mucus obstructing the bronchi. If the patient be made to cough we may perceive a souffle that would otherwise have escaped notice, and this.

souffle must always be looked for in the axillary region. We must not mistake for a souffle the occasional roughness and intensity of the breath sounds below the clavicle sometimes met with in emaciated aged persons. True bronchophony is rarely met with though the quavering voice of certain subjects may simulate ægophony.

All these physical signs, when present, are very fugitive in aged subjects in whom pneumonia as a rule runs a rapid course to suppuration, grey hepatisation, which is exceptional in the adult.

The temperature in pneumonia of the aged has been thoroughly investigated by Charcot and Dermont, the latter having selected this as the subject of his inaugural thesis. It may run its course without any rise of temperature, but we must bear in mind that in the aged 99° F. is to be taken to indicate a febrile re-action. When the temperature rises, says Dr. Etienne, it usually departs from the classical type by the discontinuity and irregularity of the oscillations. One of the salient features is the tendency to ill-sustained temperatures and rapid decline from a fastigium which may have been quickly reached. The fall is not sharp as in the adult, but is more of the nature of lysis, and may be followed by hypothermia.

The circulatory disturbances are very important. The pulse is precipitate, arhythmic and irregular, with intermittencies, indicative of weakening of the myocardium which may already have been diseased, even before the supervention of the pneumonia, as is often the case in advanced age.

The digestive disturbances comprise vomiting, which often ushers in the attack of pneumonia, a furred tongue which is red, dry, cracked and shiny, all valuable diagnostic signs, and of assistance in prognosis.

The urinary secretion is usually scanty and the urine dark in tint, depositing urates and colouring matter. There may be some albumin, the pro-portion of urea being increased and the chlorides diminished, the latter increasing after the crisis.

With regard to the nervous system there is restlessness or very pronounced prostration. Delirium occurs under three sets of conditions: (1) As an initial symptom soon followed by the classic signs of pulmonary localisation; may come in in the course of a recognised attack, in which case it is delirium of acts and words: (3) delirium may be almost the only symptom, respiration being at most rather more laboured than usual and without fever. Senile dementia may suggest itself, but the dry tongue and ex-Senile dementia amination of the thorax will clear up any doubt.

Clinical Forms.—This description of pneumonia in the aged is the most frequent, most nearly resembling the disease as met with in adults, but in addition to this variety there are several others with which we ought to be familiar. (1) The adynamic form is common in the aged. Enfeeblement and prostration predominate; the pulse is small, irregular and the complexion leaden, the breath fœtid, and diarrhœa copious. The subject is very feeble and indifferent, and succumbs in this state. (2) The ataxic form is mostly met with in alcoholic subjects. There is violent delirium and terrifying hallucinations with tre-mors, gnashing of the teeth and even carphology. (3) The latent form is one of the most interesting varieties. The patient merely complains of vague discomfort with loss of appetite and some muscle ache. The facial aspect changes, and we are

tempted to suspect gastric embarrassment, but the general state becomes worse, the tongue becomes dry, and on auscultation we hear the typical pneumonic souffle. (4) The abortive form is characterised by its mildness and short duration. It generally comes on suddenly with well-marked symptoms, followed by a sudden fall of the temperature, as in the adult. It may recur, but fortunately is usually benign, though if repeated, it may lead to death from cardiac failure. (5) The apoplectic form may simulate an attack of cerebral apoplexy with accompanying hemiplegia. This pneumonic hemiplegia is only met with in the aged, and is probably to be attributed to an organic predisposition, consequent upon previously existing lesions of the bloodvessels of the encephalon.

Course and Termination.—As has already been shown, pneumonia in the aged does not run the cyclic course met with in the adult, If it is to terminate in recovery it progresses slowly, and resolution is delayed, defervescence only taking place towards the twelfth or fifteenth day. Polyuria, sweating and herpes, which usher in the fall of the temperature in the adult, are usually wanting here. The resolution of the anatomical lesion may be incomplete, in which case the general health continues to be unsatisfactory, the typical signs persist, and the lesion tends to chronicity and pulmonary sclerosis. Even after recovery recurrences and relapses are common. nately, pneumonia in the aged for the most part ends fatally. In fatal cases the disease runs a rapid course and soon suppurates. Death is due to the pulmonary lesions which cause asphyxia or constitutional intoxication. Nervous exhaustion may also be a cause of death, which, however, is more frequently due to myocardiac failure. Nevertheless, although the prognosis is grave, it is by no means hopeless, and in any case it is

less ominous than in broncho-pneumonia.

Diagnosis.—The diagnosis of pneumonia in the aged is not difficult, but it must occur to us, if it so often escapes recognition in the aged, it is because the constitutional symptoms and functional signs being so ill-marked do not draw attention to the chest. Whenever we are called to an old man who complains of weakness and digestive disturbances, with epigastric pain, we must look at the tongue, count the pulse and auscultate the chest carefully. If the tongue be dry and the pulse small and irregular, we ought, even before examining, suspect pneumonia. In three-quarters of the cases auscultation will reveal a deep-seated souffle, and percussion more or less dulness, thus confirming the diagnosis.

We must not look for any rise of temperature to confirm the nature of the malady, and in every instance the temperature should be taken in the rectum, which is more trustworthy than in the armpit. In the delirious and the apoplectic also we should think of pneumonia. We must not forget that the physical signs themselves may be lacking, or may be masked by the emphysema, the peculiar resonance of the voice, and so on. Expectoration may be absent, but if present, it should be examined microscopically and cytologically. We shall find pneumococci characteristic endothelial cells. Investigation of the blood is of great assistance, the leucocytic formula with polynucleosis being very characteristic of pneumonia, and we may also succeed in finding the pneumococcus.

Treatment.—Prophylactically we should enjoin avoidance of every possible cause of infection and chill. There is no specific treatment for pneumonia in the aged any more than in adults, anti-pneumococcal serum has useless. All we can do is to maintain the general state and combat the prostration by the aid of alcohol, acetate of ammonium and cinchona. The heart should receive special attention, and we must have recourse to caffeine or sparteine, but digitalis seems to be the best agent of this sort in the aged. It reinforces the heart's action, restores arterial tension, moderates the pulmonary congestion and, more particularly, promotes diuresis, which is indispensable to the elimination of the pneumococcal toxins. way of local measures, mustard poultices and dry or wet cupping are very useful.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by William Taylor, M.B., Dub. Univ., F.R.C.S.I., Surgeon to the Meath Hospital and Co. Dublin Infirmary, etc. Subject: "Cerebral Abecess."

### ORIGINAL PAPERS.

### HOW MUCH PROTEID DOES THE BODY REQUIRE?

BY ALEXANDER HAIG, M.A. AND M.D. Oxon., F.R.C.P.,

Physician to the Metropolitan Hospital and the Royal Waterloo Hospital.

I REGARD it as unfortunate that there is so little precision in the statements of some of those who write on the subject of quantity in food. Thus you may see in a scientific journal such a statement as:
"His meal consists of one or two herrings, some toast, and a cup of milk." This is obviously quite valueless, except as indicating the kind of food the patient likes, and this might have been recorded in three words—fish, toast, milk. If it is worth while to state quantities at all, why not state them precisely? "Some toast" may mean half a loaf, or a three-cornered slice from the toast-rack. "A cup of milk " may mean 5 ozs., if a tea-cup or 10 ozs., if a breakfast-cup. To be of use such a statement should read: "Herring, 6 ozs.; toast, 3 ozs.; milk, 10 ozs."; and from this it is easy to calculate that the meal contained some 630 grains of proteid-a good, useful meal, about half a day's food for a man who only requires 1,300 grs. a day. Yet, from statements like that mentioned, it is sometimes inferred that such a man lives on very small quantities of proteid, and that other people take two or three times as much as is necessary This might be true if the above statement meant: herring, 2 ozs.; toast, ½ oz.; milk. 5 ozs.; but it is very far from being true if the quantities are those previously mentioned, and, as no definite quantities are given, it is open to us to take it either way. What I complain of is, that there is no scientific accuracy about such statements, and that false conclusions are only too likely to be drawn from faulty pre-

But, to come to our question of how much proteid is required. When I was a student, thirty years ago, physiologists taught us that 3 to 3½ grs. of urea must be excreted daily for each pound of bodyweight; and this is equal to from 0 to 10½ grs. of albumen consumed. Then, the Voit standard for labouring-men goes as high as 12, or even 13 grs. per pound. But, more recently, the researches of

Professor Chittenden have suggested to him, and, through his writings, to others, that this is nearly double the quantity we ought to take, and that most people can live well on about 6 grs. of albumen per pound per day. If this is so, the old physiologists were wrong, and the Voit quantities were quite unnecessary. Hence, most of the peoples of the world are, according to such statistics as we are able to collect, at present taking at least 8 or 9 grs. per pound, even when food is scarce and difficult to obtain, thus consuming nearly 50 per cent-more than is necessary. Thus, as Chittenden suggests, a great economy in proteid can easily be brought about.

In these days of increasing poverty and impending famine, it would be a most fortunate thing if these investigations turned out to be correct, and no one would be more pleased than myself if this were so. Though one can reduce the daily turnover of uric acid for a man of 140 pounds from 22 grs. to 12 grs. by shutting out unnecessary xanthins in his food, if this man could live on 6 gre. of proteid in place of 9 grs., the uric acid would be further reduced to 8 grs. per day—1.0 inconsiderable saving in the work of the excretory organs—and he would

live more cheaply as well.

I regret that neither time nor space will permit me to go deeply into scientific physiology, but I will point out in passing that I have for years believed that the celebrated Faulhorn experiment really furnished no proof that force was derived from non-nitrogenous food (see "Uric Acid," Ed. VII., p. 342). Then the theory of nitrogenous equilibrium, on which these recent investigators lay so much stress, seems to me to be almost equally badly founded. For they are here asking us to believe that Nature is little better than a fool, in that, when presented with some excess of that, for her, most valuable substance, proteid, she straightway breaks it up as quickly as possible and passes. it out of the body, and then, when the day of famine comes, she has no reserves. But a very little increase of peristales would pass this excess of albumen unabsorbed, and save all this extensive metabolism, undertaken, so those physiologists tell us, merely for the purpose of excretion. And this is exactly what Nature does in those who habitually overfeed. A little congestion of the liver results in an engorged condition of the veins that empty into it, and then a little increased outpouring of fluid (a constant result of veinous congestion in all parts of the body), with an increase of peristalsis, results in two loose stools a day, and a considerable part of the patient's excess of albumens is passed out unabsorbed, and then the urea excreted by no means corresponds with the proteids swallowed.

Surely it is much more likely that Nature stores for future use any excess of proteid which is given her, and this, as I have pointed out (prev. ref.), has been at least suggested by the work of other physiologists. But, if this is so, I shall be asked, Whence comes the excretion of nitrogen that immediately follows the ingestion of proteid food? The answer, I think, is, shortly, this, that Nature lets go her effete, or partly effete, nitrogen only in proportion as she receives new proteid to replace it. the outgo generally corresponds with the income, and Nature is, perhaps, not quite so foolish as they would have us believe. They have found nitrogenous equilibrium at various levels, because Nature only excretes so much effete nitrogen as she can replace. Then, in absolute starvation, as physiologists have pointed out, she holds on even to the effete nitrogen as long as possible. wonder those who performed the Faulhorn experi-ment on a non-nitrogenous diet did not get a sufficient excretion of nitrogen to account for the force produced. This was no proof that sufficient nitrogen was not metabolised to account for the force produced, but merely showed that Nature, being short of proteids, held on to such nitrogen as she had, in the hope of getting more out of it. Besides this, the excretion of nitrogen in this experiment was only watched for six hours after the labour was concluded, and this, as I know from my own experiments, was much too short a time to clear all the effete nitrogen out of the muscles, even in the well-fed.

The real question is, however, at what level of proteid supply does Nature do the best work, make the best blood, produce the least friction, and the smallest internal expenditure of energy for a given number of foot-pounds of external energy produced?

Fortunately for us, as practical physicians, we can get an answer to this question, which is at once independent of doubtful physiology and easily available for every-day work. We have passing in front of us day by day scores and hundreds of men who are constantly making most interesting physiological experiments upon themselves, and we have only to keep our eyes open and read the results.

Practically, when any normal body is given less proteid than it requires, it first economises—i.e., lives on as little as possible, in the hope that the hard time will pass, and then takes from its own tissues what is absorutely necessary, keeping up bulk, perhaps, to some extent by replacing albumens by fat, and finally, when it cannot get enough proteid from any source, it breaks down. And fats, we may remember, are more likely to be laid down when proteids are deficient, and more likely to be completely combusted when they are plentiful, for, as is well known, animals that have to be fattened must be given diminished proteids as well as increased carbohydrates and fats.

Now, some time before the danger-point of proteid starvation is reached, there are two outward. and visible signs which fly as danger-signals for all who will read them. The first of these is de-pendent on the fact that the rate of the capillary circulation of the skin is the result of two factors: (1) The obstruction in the circulation produced by uric acid in the blood, and (2) the power of the heart muscle. Now, one effect of starvation of proteid approaching the danger zone is diminished vigour of the muscles in general, and eventually of the muscles of the heart, and this brings about slowing of the capillary circulation in the skin, a physiological and pathological sign which I have invented a small instrument (a) to measure.

If the normal rate of the capillary reflux is 6 half-seconds, it may be slowed by such proteid starvation to 7, 8, or 9 half-seconds. For the other signs of this condition, and for the method of distinguishing the slowing due to heart failure from that due to excess of uric acid, I must refer to my books which treat of the circulation. "Heart Failure as the Result of Deficient Food," Medical Record. New York, May, 1906.
The other danger-signal is found in the quality

of the blood, which falls off as absolute proteid starvation is approached. Nature cannot save those from anæmia who are underfed, nor can she make good blood, even with the help of the most powerful drugs, while proteids remain deficients This also I have invented an instrument to measure, namely, a colour-card (b), for comparison with the mucous coverings of gums, lips, and conjunctivæ, from which it is easy to read off the approximate blood quality. If normal is represented by the

(a) Capillary Dynanometer. Hawkaley, Oxford Street, W. Price, half-a-guines. half-aguines.

(b) Colour-Card. Bale and Danielsson, Great Titchfield Street,

W. Price Is.

numbers 1.0 or 1.1 (opposite the darkest colours on the card), people approaching the starvation danger-zone will show colours of .7, .6, or even .5-i.e., less than half the normal colour.

I find, from nearly thirty years of clinical experience, that few people can remain below 9 grs. of albumen per pound without loss in both these directions; their capillary circulation slows, because their heart loses power, and their blood quality falls because there is deficient production of its normal elements.

I may say that this 9 grs. per pound is to be calculated on a quite normal individual not carrying an excess of adipose tissue, as it is his normal muscle structure we have to nourish, and not the adipose he may have put on top of it when he becomes very sedentary in later life. And here there is a source of fallacy and misunderstanding, for it may be said that a person lives on 6 grains of proteid per pound, and this statement may be true in fact, and yet very misleading. Let us take as an instance a woman of middle age weighing 168 pounds; now 168 × 6 equals 1,008 grs. per day; but her real weight, that of her original bone and muscle structure before she became stout, was only 126 pounds, and 126 x 9 equals 1,134 grs. per day; so that my calculation on her real weight only requires this quantity, or but little more, than she is taking. We see, then, that it is quite untrue to say that such a woman is living on 6 grs. per pound; she is really living on 8 or 9 grs. But those ignorant of physiology may be misled into starving themselves by such state-

It has been my fortune to see quite large numbers of people who have been attempting to live on less than 9 grs. per pound, and, with one or two doubtful exceptions, I have never seen anyone who succeeded. I have seen, on the contrary, many who failed and broke down in the attempt, and it was this experiment, constantly repeated, which led me to fix on 9 grs. for the sedentary, and 10 or 101 grs. for the active or hard-working adult. Thus my experiences are in complete accord with the teaching of physiology thirty years ago.

I have also had not a few who came to me, asserting that they were producing much force and living well on less than my quantities, but a collection of urine and estimation of urea in these cases has generally shown quite sufficient urea per pound, and effectually disposed of such claims. These people are under-estimating the quantity and proteid value of the food they eat, which, if they never weigh it, is not difficult to do.

Such having been my experience in a large number of cases over many years, I cannot help thinking that there must be some fallacy about the results obtained by Professor Chittenden, but I shall be prepared to believe them when I have seen cases living for three, four, or more years on 6 grs. per pound of real body weight, and keeping up on this a perfectly normal circulation and a normal blood condition. I know that some of his cases are said to have lived on these quantities for four or five years, but there are no records of circulation and blood-condition before and after.

In conclusion, I can only advise practical workers, who have no time to follow physiological work, which apparently rests on some rather dubious foundations, to leave physiologists plenty of time to work out their various theories, and, meanwhile, to trust to clinical records which are easily made, and have been proved by experience to be reliable.

AMONG the survivors of the recent terrible earthquake at Messina is Professor San Felice.

### SOME REMARKS ON

### INTERMENSTRUAL PAIN. (a)

By J. SPENCER SHEILL, F.R.C.P.I.

ALTHOUGH in practice we are frequently brought face to face with sufferers from this complaint, yet it is surprising how scarce is the literature upon the subject, and how imperfect our knowledge of the

affection is.

We probably all agree that the alleged cause of this troublesome affection is purely conjectural, inasmuch as we have no means of proving that the generally accepted theory that intermenstrual pain is due to an ovarian turgescense is the correct one; nevertheless, if it were not directly connected with the function of the ovaries in producing ova, it would be difficult to reconcile with it the fact that during pregnancy and lactation, when ovulation is usually suspended, regular monthly sufferers from this pain remain quite immune. The pain, too, is commonly complained of in the "ovarian region of Head" or in "the back," though its character tells us nothing, for it appears to be as often "dull and aching" as it is "sharp and cutting."

We do know, however, that sufferers are always at the age of sexual, and therefore ovarian, activity. Some patients are troubled with a vaginal discharge during the period of pain, but I think, in the large majority, this can be traced to some associated affection of the internal genital organs, such as endometritis, and so forth.

There appears to be no connection between intermenstrual pain and dysmenorrhœa, for there are quite as many patients whose menstrual periods are free from pain as those in whom pain is a prominent feature. Yet here is a letter, dated the 16th of last month, from a lady who had suffered from dysmenorrhœa; this latter complaint proved quite amenable to treatment, but you will see that the cure was as bad as the disease, for we learn from her letter that she has substituted intermenstrual pain for the dysmenorrhœa. It is true that this patient is of a highly-strung nature. Time alone can tell if this new development in her is a mere coincidence; it may be but fleeting, or it may have come to stay, if the treatment which I shall speak of later is without avail. Sterility is spoken of as existing in a large proportion of intermenstrual sufferers; this patient, as well as a number of others under my care, has been married some years and, as yet, has not become pregnant. Here is an extract from her letter:—"The period came perfectly up to time and lasted about four or five days. I did not suffer any pain, but about ten or twelve days before I had very bad pains in my back, and felt as if every day the period was going to begin, but it did not start until the proper time.

Intermenstrual pain cannot, I think, be labelled as a mere nervous manifestation, for the class of patient it is frequently seen in is anything but the nervous type; and, moreover, removal by operation of the ovaries has been known to cure cases, which is contrary to what we should expect in merely an ovarian neurosis. If we accept, as I believe we must, the idea that intermenstrual pain is a result of a physiological turgidity of the ovaries, or of one ovary—a forerunner of ovulation and of menstruation—how can we explain why it is that all ovulating women are not martyrs to intermenstrual pain?

This, in my opinion, is best accounted for in this way: the turgidity is due to circulatory changes, and all patients are not alike as regards blood and

(a) Abstract from a communication read before the Obstetrical Section of the Royal Academy of Medicine in Ireland, Dec. 11th, 1908.

blood-vessels. This being so, it will be in the direction of checking excessive, or rectifying abnormal, local or general, circulatory phenomena that our attention will be turned when dealing with the question of treatment.

A good deal of work has recently been done in connection with the relationship between menstruation and calcium metabolism, and it has been shown that there is a considerable diminution in the amount of lime in the systemic blood immediately preceding menstruation, and that lime salts again begin to accumulate after menstruation has ceased; thus, as one would expect the "calcium content" of the blood is at its maximum point about midway between two periods. We know from the teaching of the physiologists the important influence exerted by lime over muscular contraction, especially marked upon the cardiac muscle and the muscular coat of the arterioles. If too little lime is present a weak contractile power results, and vice versa. Is it not probable, then, that indirectly, an undue proportion of lime in the blood may be a factor in the causation of intermenstrual pain?

If ovulation is so active in this class of patient, how can we account for the relatively high proportion of cases of sterility among them? Is the ovum lost in a minute hæmorrhage following upon the rupture of a Graafian follicle from a turgid ovary?

it seems to me quite possible.

As to the treatment of intermenstrual pain, from the literature, and from—might I venture to say—the experience of those of us who have been called upon to treat such cases, we have come to regard "dilatation and curettage," "opotherapy," electricity, &c., as without beneficial effect. If we are willing to assume that circulatory disturbances are the cause, then drugs with a known specific action upon the blood circulation must be the only logical and rational form of treatment.

Professor Stevenson, of Aberdeen, published, some five years ago, observations on the action of salts of manganese in certain forms of menstrual suffering, taking advantage of the well-known effect of these salts upon the circulation in their tendency to restore the loss of normal balance between the arterial and venous systems. In patients who suffer from feelings of undue heaviness, especially marked in the lower limbs, and from dulness and loss of energy, from headaches, from skin eruptions, and from purple tone in the fingers, intermenstrual or premenstrual, we can with some confidence diagnose an abnormal tendency towards equalisation of the arterial and venous blood-pressures, and these are the cases that I have found give such gratifying results under a course of manganese. Of course, if chlorosis or other affection is associated with these symptoms, iron or other suitable drug must be administered also; but iron acts upon the blood, whereas manganese exerts its influence over the blood-vessels. Patients such as I have described almost invariably gain relief by lying down; is not this in itself an argument in favour of a circulatory disturbance being the cause.

Intermenstrual headaches, most frequently complained of in the vertex, though they may be relieved by coal-tar derivatives, will, as a rule, be permanently cured by a prolonged course of manganese, although the same drug may be useless in the menstrual form of headache. The form in which managanese is best administered is the permanganate of potassium, in doses of 2 gr. in pill form, after each meal; but, to do justice to the drug, a course of from four to eight months should be insisted upon, with, perhaps, slight remissions for a day or two, should stomach irritation super-

vene.

If the case chosen for this treatment be a suitable one, relief will follow long before the drug treatment is half over; nevertheless, it would be indiscreet to stop the medicine before six months has elapsed. If it fails, it is still of value as a diagnostic agent, failure turning our thoughts away from functional, and in the direction of organic cause, to account for the symptoms.

Taking into consideration how common a complaint intermenstrual pain is, it seems surprising the scarcity of articles upon the subject that have found their way into the literature. If so little attention and thought has been bestowed on the subject, it is little wonder if we were in a state of comparative ignorance as to its cause. Surely it is worthy of closer investigation. I suggest, if all of us here made careful observations and notes on all such cases as may come under our care for the next twelve months, a fund of valuable information would accrue.

### THE DIAGNOSIS AND TREATMENT

### PNEUMONIA IN CHILDREN.

By G. A. SUTHERLAND, M.D., F.R.C.P.Lond., Physician to the Hampstead General Hospital and to the Paddington Green Children's Hospital.

LOBAR PNEUMONIA and catarrhal pneumonia are the two forms of disease to which I shall refer. Speaking generally, one may say that the former is due to the activity of the pneumococcus, while the latter is dependent on some infective disease in the system which has specially attacked the lungs. Again, speaking generally, one finds that lobar pneumonia affects one lung, while in the case of broncho-pneumonia both lungs are involved.

A method of investigation, which is of extreme importance in the differential diagnosis of these two affections is the observation of the patient when at rest, i.e., when not crying or frightened. I am sure that my older medical colleagues will agree that much is to be learned from quiet observation of the patient. Those not so old will possibly prefer to have the patient stripped at once and attack the chest by percussion and auscultation. My youngest and most upto-date friends will probably reckon both observation and physical examination a mere waste of time, and go straight for an examination of the blood and the opsonic index, while at the same time they will perform lumbar puncture and seek to determine the organism present. All three methods are useful, more especially if carried out in their proper sequence.

Now observation ought to be easily carried out, and the results of observation in a well-marked disease like lobar pneumonia should by this time have been generally agreed to. Yet it is not so. In Rotch's "Pediatrics," published in 1906, I find some remarks on the subject of the symptoms of "Pneumococcus Lobar Pneumonia." (You see there can be no mistake about the disease.) He says: "The alæ nasi expand with each inspiration, and the dyspnœa is marked." There is much authority for this statement, the authority of tradition and many text-books; but does it possess the authority of careful observation?

In lobar pneumonia, during the early stages, i.e., before the critical period has arrived, or symptoms of cardiac or respiratory failure are present, we can observe certain changes in the breathing. It is quickened, it is shallow, it is often panting or grunting, and it is abdominal in type. The rapid shallow breathing is a very characteristic feature in lobar pneumonia, but it is easily overlooked. This rapid breathing is chiefly manifested though the action of the dia-phragm, so that while there is little movement of the upper costal region, a hand placed on the abdomen will feel the quick rise and fall of the abdominal wall in a way which is peculiar to lobar pneumonia and certain disturbances of the central nervous system.

You will read in many books that in children and women respiration is chiefly costal, but I venture to submit that under normal conditions it is chiefly The novelist always makes the heroine abdominal. display her emotions by a heaving chest, and it is necessary for the purposes of a story that she pass her life or such parts of it as are described in a highly emotional condition. But after the story is finished and she has reached the peaceful haven of married life, you would find that her normal breathing was abdominal in type. So with infants and children. They are highly emotional, easily frightened, and under any excitement the breathing becomes costal, but in the absence of any disturbance it is abdominal. Consequently from the rapid abdominal breathing in lobar pneumonia we may at least infer that some factor is at work stimulating the respiratory centre.

To return to the quotation, Dr. Rotch says "the alæ nasi expand with each inspiration." Now, in an excited child, as in an excited horse, the alæ nasi expand without there being anything pathological about it. But in a typical case of lobar pneumonia inspiration is not accompanied by alar movement, so far as I have been able to observe. What is well recognised as a frequent condition is the panting or grunting respira-tion. Observation of this shows an inversion of the ordinary respiratory rhythm from inspiration: expiration: pause, to expiration: inspiration: pause. expiration is panting or grunting, and is a forced movement; the pant or grunt is due to the forcible expulsion of the air through the nostrils or larynx; and this forced movement also frequently produces an expiratory dilatation of the alæ nasi. I admit, therefore, that there is a dilatation of the alæ nasi in pneumonia, but I suggest that it will be found to be expiratory, and not inspiratory. In the absence of panting breathing there is usually very slight alar

movement of any kind.

This point is of importance, further, in connection with Dr. Rotch's next remark—"the dyspnosa is marked." For if inspiratory dilatation of the alæ nasi were present, it would be a strong argument in favour of dyspnœa. One sees the alæ nasi acting and concludes there is dyspnœa, but if the action of the alæ nasi is expiratory that argument falls to the ground. Now, observation will soon convince one that in a typical case of lobar pneumonia in a child there is no dyspnœa. Can one be suffering from dyspnœa and not be conscious of any distress in the breathing? I think not. Observe a child with pneumonia, and you will fail to find any signs of distress in connection with the breathing, if your experience agrees with mine. Coughing, the pain of pleurisy, abdominal discomfort, restlessness—these may all produce a feeling of discomfort and the signs of distress, but in the clinical picture of pneumonia one will not see any evidence of dyspnæa, unless in the later stages, when pulmonary or cardiac embarrassment or respiratory failure is present.

I submit, therefore, that the leading feature of the respiration in lobar pneumonia is an acceleration of the normal rate, with, it may be, some modifications of the normal type. The frequency of the breathing may be increased in ordinary cases to 40, 60, or 80 per minute. It may go higher, and the maximum in my own experience has been 108 respirations per minute. Taking increased respiration in other conditions the maximum I have counted was 120 respirations per minute, which occurred in a case of extreme atrophy or non-development of the brain in an infant, and was presumably due to some interference with the

action of the respiratory centre.

Let us next contrast the respiratory conditions in lobar pneumonia with those seen in catarrhal pneumonia. In the latter the early stage is one of bronchial catarrh, with the appearances due to bronchitis, but soon the extension of the disease into the bronchioles and alveoli changes the picture. presents the signs of obstructed breathing, usually in an increasing degree. We can see that the ordinary abdominal breathing is supplemented by a marked increase in the thoracic movement. The alæ nasi dilate on inspiration, the larynx descends, the clavicles and sometimes the shoulders are raised; there is a sinking in of the soft tissues above the sternum and below the ribs; the sterno-mastoid and scalene muscles can be seen and felt to be acting strongly; and with increasing cyanosis the child may be unable to lie down, and sits up in order to aid the respiratory muscles. This is a picture familiar to all, and it is one in marked contrast to that of lobar pneumonia. The distress and dyspnœa in catarrhal pneumonia are obvious, while in lobar pneumonia they are conspicuous for their absence.

Let us pursue the course of these diseases further. In lobar pneumonia we may have a period of distress and dyspnoza before the crisis, but these are due to cardiac or respiratory weakness which are not evidenced by any pulmonary or cardiac lesions. In other words, one cannot find in the lungs or in the heart any cause for the respiratory distress which may develop in some cases. It may be said that the consolidation of a lobe is a sufficient cause, but this is disproved by the fact that when the crisis occurs the respiration is relieved at once, although the solidity of the lobe of the lung remains unchanged. solidity of the lobe of the lung remains unchanged. In the creeping form of lobar pneumonia, in which lobe after lobe becomes involved, a mechanical factor undoubtedly exists, but this is an exceptional and complicated form. In catarrhal pneumonia, on the other hand, the signs of distress and dyspnœa tend to increase with the duration of the disease, and pari passu the signs of obstruction in the lungs increase. The secretion in the bronchi and bronchioles, and the filling up of the alweder spaces obstruct the and the filling up of the alveolar spaces obstruct the air in its passage to the pulmonary capillaries. At the same time the areas of collapse and consolidation in the lungs obstruct the passage of the blood through the lungs and to the air spaces. Hence follow dilatation of the right side of the heart, cyanosis, and in-creasing dyspucea. In short, the characteristics of this disease throughout its whole course are those of obstructed breathing.

The observation of these conditions in connection with pneumonia in children has aided me very much in the diagnosis. It is usually in the early stages of the disease that a difficulty in the diagnosis arises. At that period also physical signs may be absent and the diagnosis arises. very indefinite in the case of lobar pneumonia, and but slight in the case of catarrhal pneumonia. Further, it will probably be agreed that in both diseases the indications as to treatment on which we rely are supplied much better by the respiratory and cardiac symptoms (dyspnœa, distress, cyanosis, etc.) than by the physical conditions in the lungs as learned by auscultation and percussion.

It is also a common experience that the diagnosis from physical signs only is often an extremely difficult We meet with a considerable amount of bronchial catarrh in many cases of lobar pneumonia, and we meet with extensive pulmonary consolidation in many cases of catarrhal pneumonia. Some even hold that a typical condition of catarrhal pneumonia, so far as the pulmonary signs are concerned, may be produced by the pneumococcus. An excess of physical signs in the lungs may thus render an exact differential diagnosis difficult or impossible, unless the other conditions of the patient and the course of the illness are considered. Also it must not be forgotten that during the whole course of an attack of lobar pneumonia there may be no physical signs in the lungs, although

the other symptoms of the disease are quite definite. I do not propose to consider further the differential diagnosis of these two affections, except in so far as it bears on treatment. It is necessary to have some definite views as to the pathology of these diseases unless one's treatment is to be symptomatic, haphazard and possibly dangerous.

As regards lobar pneumonia, the facts already mentioned, and many others given in the text-books, seem to suggest that we have to deal with a general (pneumococcal) infection, with a local and gross manifestation in the lung, and with a local and symptomatic manifestation in the central nervous system. The general blood infection and the pulmonary lesion do not at present lend themselves to any specific treatment, nor do they in the vast majority of cases call for any treatment at all. The effect on the nervous system is different. It may be described as toxic in character, affecting the whole cerebrum at times, but tending more especially first to stimulate and later to paralyse the respiratory and cardiac centres in the medulla. The character of the respiratory trouble and the tendency to cardiac failure support the view that the medullary centres are involved. It is from the dis-turbance in these centres, and not in the lungs, that danger threatens the patient, and it is to the main-tenance of the vitality of these centres that our therapeutic efforts should be directed.

peutic efforts should be directed.

In catarrhal pneumonia we have probably in all cases, certainly in the majority, a blood infection also, such as measles, whooping-cough, etc., and a local infection in the lung. The general infection is not at present amenable to any direct treatment. The physical signs in the lungs, the nature of the respiratory trouble, and the cardiac embarrassment which ensues, all point to serious impairment of the pulmonary functions. It is the pulmonary affection that is the source of the symptoms and of danger, and it is to the lung condition that our therapeutic efforts must be directed, while at the same time the prolonged and debilitating nature of the illness necessitates general tonic treatment.

TREATMENT.

Certain general lines of treatment are to be carefully followed in all cases of pneumonia, such as rest in bed, warmth, a cool and fresh atmosphere about the patient, and an absence of excitement. Especially would I emphasise the importance of seeing that the patient's body and limbs are kept warm, while the air about him is kept cool and fresh. The former is secured by a sufficiency of blankets and hot bottles, regulated so as not to induce sweating from over-heating. The cult of fresh air has been rather pushed to an extreme lately, and in America young patients suffering from pneumonia are treated in midwinter entirely in the open air, where the temperature may be anything from zero to 40° below it. There is no therapeutic value in breathing air at this temperature. On the other hand, hot air—say above 700—is not so stimulating and refreshing to the patient as air at a temperature of from 62° to 60°, and it is a very good rule to regulate the bedroom temperature accordingly. Very confidently may one assure anxious relatives that the patient will not "catch cold" from breathing such air, and that his personal comfort will be increased, provided the body is kept warm.

The diet in both diseases will be that suited to a febrile illness, and should be characterised by digestibility, simplicity, regularity of administration, and strict moderation as to amounts. Milk, whey, Benger's food and milk, chicken and mutton broths, will be found sufficient during the acute stage. If, however, the appetite is maintained, and the patient will take readily bread and butter, or simple pudding, or an egg, such food will probably be digested satisfactorily. While a febrile patient should not be coaxed to take solid foods, he should not be refused them in the presence of a good appetite. In these pulmonary affections great care should be taken to avoid abdominal distension from flatulence, which interferes with the free movement of the diaphragm. An excessive fluid diet is very apt to induce flatulence.

Stimulation.—In the case of lobar pneumonia, the oung patient will frequently pass safely through the illness without there being any necessity for stimula-tion. When it is called for, the period will be at or about the crisis, and will be, as a rule, short. On the pathological grounds stated above, the stimulation should be directed to the medullary centres, and strychnine and alcohol will be found the most efficient. In the case of creeping or massive pneumonia, in which the whole of one lung, or extensive areas in both lungs, may have become solid, we may find that the available respiratory area has been so much diminished that respiratory distress follows. There is not a sufficient area of surface for the interchange of O and CO<sub>2</sub>. In such a condition the inhalation of oxygen is of undoubted value, as it meets the difficulty of a diminished area of absorption by an increase in the amount of the available supply of oxygen. The indication for its use is cyanosis, temporary or persistent, and the value of the treatment can be quickly decided by its effect on the patient.

In the case of catarrhal pneumonia, stimulation should be directed as far as possible to the lungs and heart. As the disturbance in the latter is chiefly a mechanical one, and due to the obstruction of the circulation in the lungs, it is well to begin treatment with digitalis or strophanthus early in the disease. Alcohol has the disadvantage of tending to increase pulmonary catarrh when given in full doses for any length of time. It should therefore be given in small amount. Oxygen will also be useful in cyanosed patients, and

citrate of caffein is a useful cardiac stimulant.

Local Applications.—It is very doubtful whether local applications have any influence in pneumonic consolidation, and they have the disadvantage of disturbing the patient. Consequently the application of a loose wool jacket, suited in thickness to the season a loose wool jacket, suited in thickness to the season of the year, will probably be more efficacious than many poultices or fomentations. Pleurisy may induce such pain that fomenting or the application of a couple of leeches is called for, but this is exceptional in a patient well nursed in bed. Very few of my cases of lobar pneumonia are treated by local applications to the chest. In catarrhal pneumonia, on the other hand, hot, moist applications seem to serve a definite object in the relief of spasm in the bronchial tubes and conversion in the pulmonary blood-vessels. In object in the relief of spasm in the bronchial tubes and congestion in the pulmonary blood-vessels. In the use of poultices, fomentations, or turpentine stupes, while the intermittent use is beneficial, the constant use, day and night, is, I believe, prejudicial to the patient's progress. Apart from the state of unrest necessitated by the frequent renewal, the desired effect is probably secured by one poultine, and no effect is probably secured by one poultice, and no benefit follows from others continuously applied. One application every four, six, or eight hours, as the case

may be, appears to give better results.

Another method of securing the same result, the relief of spasm and congestion, is by means of a hot bath or a hot pack. The restless and distressed bath or a hot pack. The restless and distressed patient will often sink into a quiet sleep after one of these. In conditions of extreme cyanosis, dry cupping over the back, or blood-letting up to three or four

ounces may be employed.

Steam inhalations require to be used with great aution. The indications would appear to be (1) an caution. absence of secretion about the bronchi; and (2) the presence of spasm about the bronchi. The continuous breathing of steam laden air is exhausting to the patient. The best method appears to be to place a steam kettle at the patient's bedside and to let the steam play over his face for fifteen or twenty minutes at a time. A steam tent is not necessary, and is probably injurious. The custom of keeping a bronchitis kettle steaming in the room day and night is to be avoided, as it produces a heavy and depressing atmosphere, while what we desire is cool fresh air

about the patient.

Internal Medicines.—The consolidation of the lung in lobar pneumonia does not appear to be influenced in any way by medicines, and most of those recommended have the disadvantage of inducing gastric disturbance. A simple febrifuge mixture is probably sufficient in the majority of cases. Many practitioners are of opinion that a temperature of 104° to 106° must be attacked by medicinal antipyretics, but such interference is uncalled for, is useless, and is very apt to have a depressing effect on the patient. The stage of resolution in children usually proceeds rapidly by a process of absorption through the blood vessels. If it seems unduly delayed one may with advantage give small doses of iodide of potash. Coughing in lobar pneumonia may be due to pleurisy, but is more frequently associated with irritation of the terminal branches of the vagus by the pneumonic exudation. Consequently expectorant medicines are not indicated, but rather sedatives, such as the bromides, or paregoric.

In the case of catarrhal pneumonia the indications for drug treatment are supplied by the conditions present in the lungs. There may be hyper- or hypo-secretion. In the dry catarrhal stage, ipecac, the iodides, and carbonate of ammonia are useful. For excessive secretion, belladonna or atropine in an acid

mixture will be found beneficial. Opium is contraindicated because of its depressing effect on the respiratory centre, whereas atropine has a distinctly stimu-It must be admitted that the field for lating action. medicinal therapeutics in cases of catarrhal pneumonia is a somewhat limited one. At the same time, by a judicious use of drugs, and more especially by the avoidance of those which are injurious, one may do a great deal for the relief of the patient.

### CLINICAL RECORDS.

ROYAL CITY OF DUBLIN HOSPITAL.

Case of Pernicious Anamia, (a)

Under the care of ALFRED R. PARSONS, M.D., F.R.C.P.,

#### Physician to the Hospital.

A. B., æt. 45, formerly a fireman on board a crosschannel steamer, came to the Extern Dispensary of the Royal City of Dublin Hospital on September 10th, 1908, suffering from weakness and shortness of breath. His appearance was so suggestive of serious illness. that he was admitted to the medical ward. On inquiry he stated that four or five months ago he had an attack of influenza, and he attributed the onset of his present illness to starting work too soon, because shortly after resuming work he felt a throbbing in his head, and he felt sick till he sat down. A little later he got headache, palpitation of the heart, and weakness in his legs. In spite of these symptoms he continued at work for five weeks, though he felt as if he had a ropeacross his chest and abdomen, and as if his head were bursting. He remained at home for ten weeks, but as he was making no progress he came to the hospital.

Previous History.—He always enjoyed good health,

and had been in the employment of his present company for 35 or 36 years. Till one year ago he acted as fireman; more recently he has acted as a collier.

Family History.—Both parents died aged about 60years. The father succumbed to a paralytic stroke, and the mother to an unknown cause. They had eight children, all of whom were alive except one boy, who succumbed to an accident.

The patient was twenty-one years married. He had

only one child, which died at birth.

Personal Habits.—He chewed or smoked three to four ounces of tobacco weekly. As regards alcohol, he was never a heavy drinker, and for the past three years had taken only an occasional glass of porter.

He took tea at every meal; he has always had a liberal supply of good food.

On Inspection.—He has abundant black hair, but the face is pale and sallow-looking. The lips and mucous membrane of the mouth are very pale, almost the colour of the skin; the teeth are carious in part and covered with tartar; the ears are white. The panicoulus adiposus is slight, but he has not wasted. The nails are white. Veins over back of hand were not visible. Neck showed marked pulsation; a gland on each side was palpable. Thorax was normal, except for a systolic murmur audible over the mitral, aortic and pulmonary areas. There was no tenderness on percussion over the sternum. Abdomen.—The liver was quite normal; the spleen not palpable; and a general examination disclosed nothing pathological. Lower Extremities.—Slight cedema of the ankles; a few cicatrices over the front of each tibia, probably traumatic in origin. The knee-jerks are easily elicited. There is no tenderness on pressure over the calves or the tibiæ; the inguinal glands are just palpable. He has frequently had oozing of blood-stained fluid from his gums, and the bowels are usually constipated. The urine had a specific gravity of 1015; was acid in reaction. It contained neither albumin, sugar, acetone, nor diacetic acid, and only a very small quantity of

<sup>(</sup>a) Read before the Royal Academy of Medicine in Ireland, Dec. 18th, 1908.

indican. On admission the temperature was 98°, and continued in or about normal for a fortnight after. The pulse during the same period varied from 96 to 108.

Blood.—Shortly after his admission, smear prepara-tions were made by the Resident, Mr. Medcalfe, which showed definite poikilocytosis, and such an increase in the white blood cells as to attract his special attenin the white blood cells as to attract his special atten-tion. No other changes were detectable at this stage in the red blood cells. On September 25th a blood count was made, and showed Hg. 20 per cent., red blood cells 1,150,000, colour index .8. Poikilocytosis was still present. I did not detect any nucleated red blood cells, but, with some searching, Dr. O'Sullivan found a few normoblests. found a few normoblasts.

Subsequent History .- In spite of all we could do, the course of the disease, even during the first fortnight, was steadily downwards. He complained of some pain in his right ear, and on September 26th pus escaped freely from the external ear. His temperature rose to 101° F., the pulse to 120. He became stupid and heavy; his temperature rose to 130. F.; he had a sharp attack of epistaxis. On October 6th he seemed to be a shade better, but on the morning of October 7th he got a profuse epistaxis, and died shortly afterwards. A couple of days before his death several blood films were made, which were of exceptional interest, especially in comparison with those made previously, and I asked Dr. O'Sullivan if he would be good enough to make the post-mortem examination. The clinical diag-

nosis was pernicious anæmia. Professor O'Sullivan, who made the post-mortem, said that the appearance of the organs under examination was similar to that found in pernicious anæmia, with secondary septic infection. The heart showed well-marked tabby-cat striation, and the liver contained a large quantitity of iron pigment. The bone marrow also suggested pernicious anæmia. The blood was remarkable and unusual. The earlier specimens showed a definite polymorphonuclear leucocytosis and poikilocytosis, with very few nucleated red blood cells. The blood films, made some days before, as well as those made after death, on the contrary, contained large numbers of nucleated red cells, and a great increase in the number of the white cells. Among the latter were numerous myelocytes. Briefly, the appearance of the organs suggested pernicious anæmia, but the blood removed some days before death was much more like myelogenous leucæmia than pernicious anæmia.

### OPERATING THEATRES.

CANCER HOSPITAL. APPENDICULAR ABSCESS .- MR. BOWREMAN JESSETT operated on a female child, æt. 9, who had been admitted for obscure abdominal pain accompanied by high temperature and constant diarrhea; also a quick pulse and some abdominal distension, with a slight tenderness over the whole of the abdomen. The tongue was furred, and there was some vomiting. The diagnosis was very obscure, and it was agreed to treat the child expectantly, but four or five days after admission considerable dulness was noticed over the right side of the abdomen extending from the diaphragm and liver to a point on a line with the umbilicus downwards, and backwards to the spine. There was no dulness over the iliac regions, and very slight tenderness. The general condition of the child was, on the whole, satisfactory. There was no sense of fluctuation for another three or four days, when it was decided that this dulness was due to a deep-seated abscess, and operation was imperative. Mr. Jessett made a free opening directly over the dullest parters the swelling, and came down on a large abscess cavity, letting out a pint and a half of evilly-smelling He then made a counter-opening in the loin, and passed a large drainage tube through, the end of which protruded from each opening. The patient was considerably relieved. The temperature dropped, but in the course of a day or two rose again to 100° or 101°, the pulse being very rapid. A week afterwards Mr. Jessett's attention was drawn to a large, sausage-

shaped swelling in the left iliac region. This was rather painful on pressure, and fluctuation was thought to be felt. This swelling appeared to be much larger at some times than at others. It was decided to cut down upon it with the idea of its probably being a psoas abscess. On making an incision over the most prominent part of the swelling, a cavity was opened admitting the finger, which could be easily pushed upwards for about 3 ins. along the outer side of the rectus muscle. A small quantity of bad pus escaped. A drainage tube was inserted. Again the temperature dropped, and the patient appeared to be going on satisfactorily; but another swelling formed over the right iliac region. This was opened, and pus evacuated. On passing a probe downwards, this cavity was discovered to communicate with the large abscess on the right side which had been originally opened. The cavity was thoroughly cleansed out, and syringed through with peroxide of hydrogen, and a drainage tube in-serted. From this point the child gradually improved, and eventually made a good recovery.

Mr. Jessett said the case was most interesting and

instructive, as the original symptoms did not in any way point to mischief in the appendix; the fact that the dulness was first discovered below the ribs posteriorly and extending upwards to a level of about the ninth rib, and not traceable downwards to the iliac region, seemed to negative the idea that the abscess originated from the appendix, but the subsequent abscess forming in the right iliac region, he thought, clearly pointed to the supposition that the appendix was the original seat of the mischief. He thought there could be no doubt that this was one of those He thought cases in which the appendix was situated and extended upwards behind the cæcum, causing inflammatory mischief in the retro-peritoneal cellular tissue, which extended upwards towards the diaphragm. The question would arise, he remarked, whether earlier opera-tion would have been advisable, but seeing that there was no sign of any abscess to be found until the dulness was discovered beneath the ribs posteriorly, he questioned very much if the patient would have been placed in a more favourable position if the abdomen had been opened and an attempt made to remove the appendix.

### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

MEETING HELD FRIDAY, JANUARY 8TH, 1909.

The President, Sir Thomas Barlow, Bart., K.C.V.O., in the Chair.

Dr. James Mackenzie demonstrated his instrument, the clinical polygraph. He said that it had been invented to replace the bulky revolving drum, covered by smoked paper, which had formerly been in use to record cardiac and other vascular movements. By taking the time of the radial pulse as the standard, he had been able, by a comparatively simple instru-ment, to locate the times of various cardio-vascular movements. The essential parts of the instrument were a small cup for receiving the impressions of the pulsations, and a tube for transmitting the impressions to a tambour and lever, the tambour being attached to a Dudgeon and Jacquet sphygmograph. The small cup for receiving the impressions, or receiver, was simply a small shallow metal vessel, circular in shape. The open mouth was applied over the pulsating part, so that its edges were closely adapted to the skin, and all communication with the outer air was excluded. art communication with the outer art was excluded. From the roof arose a narrow pipe, half-an-inch in lergth. To this was fitted an india-rubber tube, 3 or 4 feet long, the other end of which was connected with the tambour. The tambour supported a writing lever about 6 in. in length, and was also attached to the upright stem of a Dudgeon's sphygmograph. this instrument he had taken very many observations,

and had learnt much, but he had found later that inere was often need for a continuous tracing. This had led to the invention of the ink polygraph, an instrument when he was a second of the ink polygraph, and instrument when he was a second of the ink polygraph, and instrument when he was a second of the ink polygraph, and instrument when he was a second of the ink polygraph, and instrument when he was a second of the ink polygraph. instrument whereby tracings of indefinite length, made by ink, could be taken on a gradually unwinding roll of paper. Part of this instrument was a box containing clockwork to move a roller, and so gradually unwind the paper. There were two tambours with levers, one to record the radial pulse, the other the movement under observation. It was fitted with a time-marker, which was also worked by clockwork. Dr. Mackenzie then showed many records which had been taken by the polygraph, and demonstrated the method by which they should be read, and the inferences to be drawn from them. Among other important conclusions he said that he had frequently found a prolongation of the interval between the auricular and ventricular waves in the jugular tracing in advanced cases of mitral stenosis. This he could only ascribe to an alteration in the excitability of the auriculowhich occurred in cardio-sclerosis.

Drs. Mackenzie and Lewis then demonstrated the

method of using the instrument on the human subject.

Dr. Paul Chapman (Hereford) said that he had previously been doubtful whether the times of the various impulses could be definitely measured by Dr. Mackenzie's instrument. He had himself used an instrument by which the venous and other pulsation was adapted to a cardiac record, and not, as in that of Dr. Mackenzie, to a radial pulse record. His own method required more skill to obtain records of any value. He had now no doubt that the sequence of events was as Dr. Mackenzie had described, and believed that the sequence of events was as Dr. Mackenzie had described, and believed the sequence of t lieved that the instrument shown was of great value i.1 correlating cardiac and vascular records with the signs found by other means of clinical investigation.

Sir LAUDER BRUNTON said that the subject was full of difficulties. He admired greatly Dr. Mackenzie's skill and patience in obtaining these records, and his ability in deciphering them. He thought that the polygraph would help much in the diagnosis and in the application of medicines to cardiac disease. He had used several recording instruments, but considered this the most convenient, though less expensive than many he already possessed.

Sir JOHN BROADBENT did not understand the reason for the explanation given of the delay in ventricular contraction in cases of mitral stenosis. He thought that it might be explained in another way. As the crifice got narrower and narrower, it naturally took more and more time for the blood to get through, so that the delay could be explained on a purely physical basis. He questioned the use of the term nodal rhythm. In many cases of old-standing rheumatic heart disease, and in the hearts of old people, there was often considerable general fibrosis, so that it would be very difficult to differentiate the auriculo-ventricular bundle.

Dr. Herringham paid a high tribute to Dr. Mackenzie for the work which had led to his putting forward this new method of examination, although he did not accept without question all that Dr. Mackenzie had said.

Dr. THOMAS LEWIS said that the prolongation of the interval between the auricular and ventricular systole could not be explained mechanically. During the taking of a record this change would often occur quite suddenly. For twelve months he had used the method under discussion, and thought that the examination of irregularly-acting hearts was futile without it.

Dr. MACKENZIE, in reply, said that, at this stage, it was no longer always necessary to take a tracing. His explanation of the irregular rhythm, which he had called nodal rhythm, was purely hypothetical, although he had given many reasons for it.

THE United States Ambassador in Berlin, on behalf of Mr. Carnegie, has handed to the bankers of the Robert Koch Fund, for the campaign against tuberculosis, a sum of £25,000. The fund now has a capital of £57,500.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, DECEMBER 18TH, 1908.

The President, Dr. A. R. PARSONS, in the Chair.

CASE OF PERNICIOUS AN.EMIA.

THE PRESIDENT read some interesting notes on the clinical history of a case of pernicious anæmia in a fireman of a steamship. This case will be found fully reported in another column, under the heading of Clinical Records.'

In the discussion that followed,

Dr. J. MAGEE FINNY thought the condition during life pointed rather to leucæmia than to pernicious anæmia. Every addition that could be made to their knowledge on the subject was most interesting. In a case which he published many years ago, the iron stain was found also in the kidneys.

Dr. MOORHEAD quoted two cases as showing that there must be a large number of cases of pernicious anæmia in which the nucleated cells suddenly burst out into the blood in the last days of life, and more particularly when any acute infection occurred.

Dr. TRAVERS SMITH said that if the man's illness. could be traced to mastoid disease, or if the original source of the septic infection was in the middle ear, there would be no necessity to explain the matter as pernicious leucæmia or anæmia. An elevation of temperature was not necessary in order to develop a leucocytosis. The nucleated red cells were not numerous, and possibly they and the myelocytes that appeared were compensatory to the marked hæmolysis

that was evidently going on.

Dr. BOXWELL referred to a case in which it occurred to him that the anæmia was due to a parasitic infection. He did not improve on treatment with arsenic. After two months he suddenly got much better, and he left hospital with about 65 per cent. of red cells, and hæmoglobin considerably over. In a second case he found a number of things in the blood of which he was not sure. They were like either lymphocytes or loose nuclei. In a third case—of a woman who got well, but returned to hospital and died—the postmortem showed uniformly fatty organs, with iron stain in liver, spleen and kidneys. They all had bad teeth, and the second case had an extremely septic condition in his mouth.

The President, in reply, said the case presented, from a clinical point of view, what he would call the typical aspect of pernicious anæmia. The man had no trouble from his ears or mastoid cells. There were no ear symptoms whatever until fourteen days after admission to hospital, and he believed the infection occurred while in hospital. The case might, perhaps, be put into the ill-defined group called leucanæmia, but the weight of evidence was in favour of pernicious anæmia.

Professor O'SULLIVAN, in reply, said that in thick parts of a preparation the cells sometimes became shrunken in the slow-drying, and it often became impossible to distinguish between a lymphocyte and a nucleated red cell. The difficulty did not occur in a thin preparation. There was no naked-eye appearance thin preparation. of iron in the kidneys.

CASE OF TUBERCULOSIS OF LUNGS, WITH TUBERCULOUS

TUMOUR IN CEREBELLUM.

Dr. O'CARROLL read notes of a case of above in a girl, æt. 19, who was admitted to the Whitworth Hospital on May 12th. From Christmas, 1907, she began to have dimness of sight, and later complained of occipital headache and vomiting. Her sight became worse. There was no relation between the vomiting and food. The tongue was protruded slightly to the right. There was no marked difference in the expression of the two sides of the face. She was quite intelligent; her speech was slow and slightly slurring. There was no discharge from the ears. Both knee-jerks were well marked. There was no actual wasting of flesh, and the menstrual function was right. She improved very much in hospital; but in October, during his absence from town, she complained of headache, and had bleeding from the nose. Her temperature rose; she became somewhat comatose; and lumbar puncture was performed on November 9th, about 30 cubic centimetres of fluid being withdrawn. She improved a little for a few hours, but died on November 16th, after several days in a state of coma.

Dr. PURSER said that during the performance of lumbar puncture she shrieked with headache, but it ceased in about ten minutes. At the post-mortem the only organs showing disease were the cerebellum and the lungs. He was aware that the upper lobe of the right lung was consolidated, but he was not aware of anything being wrong with the left lung. In it, how-ever, they found an enormously thickened pleura, and the whole lung was riddled with cavities. It was most remarkable that with such extensive disease of both lungs there should be so little symptoms. The patient at no time had any cough.

SPECIMENS FROM A CASE OF RICKETS.

Dr. Purser exhibited specimens of a case of rickets from a child, æt. 14 months, who had been suffering from measles, and had died from bronchial pneumonia, following measles. There were marked symptoms of rickets in the wrists, ribs, and cranium. It was rather unusual to see the changes in the ribs, and still more so in the skull, which showed enormous thickening of the parietal bones.

CARCINOMA OF STOMACH AND LIVER.

Dr. EARL showed specimens of carcinoma of the stomach and liver taken from a woman who had been in hospital only a few hours. At post-mortem the liver was found very much enlarged, and it contained so many nodules of cancer that at first sight it looked somewhat different from the ordinary secondary cancer of the liver. He found in the stomach an ulcer, which lay on the posterior wall over the pancreas. Part of the edge of the ulcer was sharply cut and terraced. He could find no other cancer in the body as a primary

Dr. TRAVERS SMITH said the woman was æt. 36. She complained of violent pains in her epigastrium, which had come on two days previously, but before that she had had no stomach symptoms. She had taken a considerable quantity of alcohol, but there were no ascites present. He examined her for a primary carcinoma, but found none.

NOTE ON BISMUTH POISONING.

Mr. Gunn read a note on bismuth poisoning.
Dr. Walter Smith recalled the history of the toxicology of bismuth. Apart from its simple mechanical effects, observations from a physiological point of view showed that it produced the phenomena of irritant poisoning. There were abundant experiments showing that bismuth produced just the symptoms to be expected from its alliance with the arsenic and antimony groups.

There were several deaths on record, so that it was a

drug not to be used recklessly, and he thought the surgeon should desist from using the sub-nitrate. Dr. HAYES said a good many cases of poisoning had been recorded by radiographers from the use of the sub-nitrate. Patients had died of overdosing, and the deaths were said to be due to the toxic effects of the nitric acid liberated. The shadow of the nitrate was denser than that of the carbonate.

Mr. Gunn replied.

### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

### FRANCE.

Paris, Jan. 10th, 1909. CORYZA.

CORYZA, or common cold in the head, is, in general, a benign affection, but it may sometimes be attended with serious consequences, by extension of the inflammation to the neighbouring parts, hence the advisability of treating it. The treatment is either abortive or palliative.

The abortive treatment, if it has any chance of being successful, should be applied at the outset, that

is to say, when there is yet but a sensation of dryness and heat in the nasal fossæ. It must be of short duration (half a day), otherwise it becomes useless creven dangerous, according to Prof. Lemoine.

Preference should be given to inhalations; aspiration of vapours of ammonia, eau de Cologne, tincture of iodine, menthol.

Brand advises:

Phenic acid, 1 dr. Liq. ammonia, 1 dr. Proof spirit, 2 dr. Water, 4 dr.

A few drops on blotting paper, inhaled several times during half a day.

Abortive powders are more active: --

Cocain, 10 gr. Menthol, 5 gr. Salol, 4 dr. Boric acid, 4 dr.

A pinch of the powder snuffed up every hour. Or:

Salol, 2 dr. Salicylic acid, 30 gr.

Tannin, 15 gr.
Boric acid, 1 oz.
Irrigation of the nasal fossæ succeeds very well in cutting short rhinitis, but it requires some patience on the part of the patient, as it is rather disagreeable at the beginning. A tablespoonful of chlorate of potash or boric acid is dissolved in warm water, previously boiled and passed through the narines by means of Weber's syphon or the douche of Esmarch. The patient should not expose himself to the cold air for two or three days after the irrigation.

An excellent practice is to paint the mucous membrane as high up as possible, with a solution (1—10) of cocain and glycerin. Ruault jugulates a cold in the head with benzoate of soda, given internally, a drachm during the day for children and two drachms for adults. Weitlauer, recommends the use of salicylate of soda

and Dover's powder:

Salicylate of soda, 1 oz. Dover's powder, 40 gr. Ess. of peppermint, 1 drop.

Mix and divide into twenty powders; one every four hours. This treatment, he says, will procure a rapid cessation of the irritation: it is both preventive and

The palliative treatment covers a series of little measures, all more or less useful. When the secretion is abundant, clear and liquid, it is very irritating, producing a very disagreeable local malaise. At this period, atropine can render service at the dose of a quarter of a milligramme (1/256 gr.). It should be suppressed as soon as the secretion becomes more consistent, when one or other of the following powders may be substituted: -

Cocain, 2 gr. Morphia, 2 gr. Tannin, 2 dr. Salicylate of bismuth, 4 dr.

Cocain, 1 gr. Boric acid, 1 oz. Fuller's earth, 1 oz.

Or: Cocain, 2 gr.

Camphor, 10 gr.

Powdered sugar, 2 dr.
A mixture of menthol (20 gr.) and olive oil (4 oz.) is very refreshing, and is commonly used.

Ointments are preferred by Prof. Lemoine, as they

insure antisepsis of the nasal fossæ:-

Camphor, 30 gr. Vaseline, 3 dr.

Or:

Or:

Menthol, 2 gr. Vaseline, 3 dr.

Or:

Salol, 6 gr. Vaseline, 1 oz

Or (combination):

Menthol, 6 gr. Boric acid, 30 gr. Salol, 4 gr. Cocain, 4 gr. Vaseline, 1 oz.

For the headache accompanying coryza, the following wafers :-

Valerinate of quinine, 6 gr. Pyramidon, 3 gr.

Antipyrine, 10 gr. For one wafer; one to three a day. ARSENIATE OF STRYCHNINE.

Arseniate of strychnine is exceedingly useful in certain chronic pulmonary affections such as chronic pronchitis, asthma, emphysema, and in broncho-pneumonia of the aged, by reason of its almost specific action on the contractibility of the muscles of Reissesen. Given in pills or injections at the dose of from 1/33rd to 1/10th of a grain, arseniate of strychnine raises the tone of the lungs and gives relief as no other treatment can.

#### ECZEMA.

Weeping eczema is quickly healed by applications of coal tar by means of a camel-hair pencii, and left to dry as long as possible (from 20 minutes to half-an-hour), after which the place is powdered with any absorbent powder (Fuller's earth). Two or three days afterwards the application is repeated, and perhaps once again, but rarely four applications are necessary. Zinc ointment completes the cure.

The only inconvenience attending this treatment is that, by reason of the colour of the ingredient, it can-not be applied to exposed parts, face, neck, hands. Otherwise, all the patients submitted to this treatment express themselves content.

GERMANY.

Berlin, Jan. 10th, 1009 At the Medizinische Gesellschaft, Hr. Rosenstein showed a large number of figures of epidiascopic projection of preparations of TUBERCLE OF THE KIDNEY.

The preparations were all taken from cases that had been operated on by J. Israel. The speaker distinguished three forms of the disease (a) the ulcerous cavernous form, (b) that of tuberculous ulceration of the apices of the papillæ, (c) the chronic nodular form; these different forms could, however, only be distinguished in their early stages. In order to distinguish the form b at the operation it was necessary not only to expose the kidney and make an explora-tory puncture, but to open widely. The speaker expressed the hope that as functional diagnosis became more perfected, the chronic form would be diagnosed so early that total extirpation of the whole organ would be no longer necessary, but the partial resection would be enough to ensure perfect recovery.

Hr. Orth pointed out that the pathological anatomist often enough saw tuberculous disease of the kidney in the early stage that had given rise to no clinical symptoms at all. He recognised Israel's division into different classes. The first commencement of the disease was found in the medulla or in ment of the disease was found in the medulia or in the calices at the spot where the mucous surface was reflected about the apices of the papille. The early appearance of the disease in the medulia was explained by the appearance of tubercle bacilli in the straight canals; in the glomeruli the bacilli must be excreted from the blood in acute miliary tuberculosis.

Of great importance as regarded the development

of renal tubercle was tuberculosis of the walls of the arteries. In this the lumen of the artery might be arteries. In this the lumen of the artery might be blocked by an infarct which afterwards became tuberculous, and from this tubercle might develop in the whole of the region supplied by the artery. Tubercle bacilli had been found in the canaliculi without the kidneys themselves being diseased (Benda), but of course the patient must have already been infared.

EXPERIMENTAL INQUIRY INTO THE INFLUENCE OF MINERAL

WATERS ON THE SECRETORY FUNCTION OF THE STOMACH.
At the same meeting Hr. Bickel contributed a note on this subject. He had performed experiments on several dogs with gastric fistulæ, and also on a girl

with an esophageal fistula made in consequence of atresia of the æsophagus from swallowing corrosive liquid. Food swallowed passed out again through the opening in the esophagus unless conducted through a tube into the opening in the stomach. A similar operation was performed on the animals experimented on. In this the speaker believed he had excluded a number of sources of error, but he was not optimist enough to think that he had excluded all.

In his experiments he had made use of representa-tives of all the groups of mineral waters that had been employed in the treatment of gastric troubles, giving a risumt of the results obtained. Although these may not be at once applicable to normal digestive processes, they form a basis for more exact

inquiry.

Changes in the Digestive Tract in Pernicious ANÆMIA.

A short note on this subject occurs in the Deutsche Med. Zeitung, 102/08, communicated by Drs. Faber and Bloch. They say that in pernicious anæmia a diffuse gastritis is often present, in which there is a tendency to atrophy of the glandular tissues, with, as a clinical symptom, gastric achylia. Disease of the intestine is not a constant concomitant, and especially there is no atrophy of the bowel, inflammation, or degeneration of the glands. Whatever the relationship is between the gastritis and the anæmia it cannot be taken that the former is the direct cause of the disease.

Gastritis with achylia is frequently met with in patients having no tendency whatever to anæmia, and in many cases of well-pronounced anæmia there was no achylia, and most probably only a very slight degree of gastritis. As it cannot be thought that the anæmia itself causes the gastritis, it may be assumed that the two are caused by the same irregularity.

The probable explanation is that the anæmia is produced by some poison generated in the system. Possibly the gastritis may arise from an effort on the part of the stomach to get rid of the poison. The intestinal tract is the part in which it may most naturally be assumed that the poison originates. When it has been determined that the bothriocephalus latter may set up a perpicious angulate and that the latus may set up a pernicious anæmia, and that the same may be said of strictures of the bowel there need no longer be any doubt on the matter.

## AUSTRIA. Vienna, Jan. 10th, 1909.

FLAT AND CLUB-FOOT.

SEMELEDER gave the Gesellschaft a description of what he called a new theory of the formation of flat and club-foot which many of the members thought was common knowledge. He set out by saying the very act of standing was performed by first fixing the hip and knee-joints, leaving the ankle as the pivot of movement, but this joint only having a perpendicular movement the centre of gravity passes through this to the heel, but if any undue force alters this, an unnatural rotation takes place and a torsion of the foot is produced, either eccentric or concentric to the axis. first symptom of these altered forces is a relaxation of the pedal muscles, producing flat-foot, which is an eccentric rotation not depending upon a habit, but an inherent force of the muscular action, or some injury like compression that produces an elastic strain on the joint. He compared the leg to an elastic prop, flexible at hip, knee, and ankle. If the centre of gravity be carried behind the knee-joints it will necessarily act adversely on the ankle-joint, forcing it outwards; if the centre be outside the knee, the fulcrum is altered and turns the foot inwards.

Benedikt said there was a good deal of truth in the argument, but he did not think the articular distorsion was so simple, nor the cause so easily explained.
EXTRACT OF THE HYPOPHYSIS.

Pál gave a brief account of his experiments with an extract which he obtained from the hypophysis of bones. By intravenous injections of the extract a temporary description in the blood proving the blood provin porary depression in the blood pressure takes place

which is rapidly followed by a rise. It resembles adrenalin in its action, although antagonistic in the renal vessels. When applied to the eye it is mydriatic in its action on the pupil. Its action on the vessels is the same as occurs with pilocarpin, which causes a dilatation, which in the renal arteries is very pronounced.

WASSERMANN'S SYPHILITIC SERUM

Bauer and Meier gave a minute description of the lechnique and efficacy of Wassermann's serum, which they had used in 381 cases with great success. In 28 genuine cases of syphilis the reaction was perfect. In the first reaction of 35 doubtful cases, 31 of them reacted as genuine syphilis, the other two as asepsis and carcinoma.

In cases of florid syphilis the reaction was perfect in 85 per cent., but not so frequent where the syphilis was over one year old. Its action was positive with greater certainty in cases of cachexia than in the robust. In other 28 cases where control experiments were conducted, 25 were positive. They believed that in all cases of syphilis it was characteristic except the lepra form, which were not constant. To obtain good results, strict attention to the technique was necessary. Salomon thought this specific reaction of Wassermann was not free from many objections. Kraus said there was little objection to the use of the serum, but its theoretical importance could not be clearly explained.

Porges questioned the advantages of Wassermann's serum, as many febrile diseases, diabetes, tumours, and tuberculosis all gave a sort of positive reaction.

LEAD POISONING.

Teleky presented two females with abnormal localisation of lead poisoning. Both of the females are bottle cleaners, which have composite capsules. The paralysis is in the muscles, usually not affected in the muscles of the thumb. Rold presented a cooper, æt. 41, with lead poisoning, but the ætiology seemed buried in obscurity. He was greatly emaciated, anæmic, and the typical pulse. In the urine small quantities of lead were present, and in the blood were granular red blood corpuscles; the latter symptom, though not a constant sign present, is irrefragable when met with.

Teleky said there were so many peculiar sources of lead poisoning that it would be difficult to conjecture the origin. It was found in children's toys, "paprika," and drinking utensils.

ANEURYSM OF BASILAR ARTERY.

Wiesner demonstrated a saccular aneurysm which had split the pons and deformed the right side of the medulla oblongata.

Chvostek gave a clinical history of the case. He said the patient was healthy up to a year ago, when he complained of headache, followed by vomiting, vertigo, deafness, imperfect vision, difficulty in swallowing and speaking. There was paresis in the left side of the body, paralysis of the right abducens and internus, and distinct paresis in the left abducens and uvula, with increased reflex on the left. There was no congestion of the fundus of the eye. The association of the paralysis of the ocular muscles while the motor nerves were intact pointed to what was diagnosed as central tubercle in the pons varolii.

## FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

THE LATE DR. ARGYLL ROBERTSON.—A telegram was received in Edinburgh on January 4th announcing the death at Gondal, India, on Sunday, of Dr. Argyll Robertson, the well-known oculist. A full account of his career will be found in another column, under the heading of "Obituary"

UNIVERSITY OF EDINBURGH.—From the annual report the past year has been a prosperous one in point of number of students, which is the highest attained for 17 years. The total matriculated students were 3,328 (including 595 women), distributed among the faculties thus:—Arts, 1,156 (505 women), Science, 295 (16 women); Divinity, 62, Law, 304 (3 women); Medicine,

1,490 (59 women); Music, 21 (12 women). Of the students of Medicine, 45 per cent. were Scottish, 19 per cent. English, 9 per cent. Irish, 5 per cent. Indian, 20 per cent. from British Colonies, and 2 per cent. foreign. Thus the proportion of non-Scottish medical students is well maintained; in particular the number of Colonial students exceeds by 34 the highest number reached at any time during 20 years. Among new Lectureships instituted is one on the History of Medicine (Dr. J. D. Comrie); the lectures will be delivered during this winter and next summer session. Dr. G. M. Robertson has been appointed Joint Lecturer with Dr. T. S. Clouston on Mental Diseases. There have been three changes in the professoriate during the year: Professor Caird has replaced the late Professor Annandale, Professors Walker and McKinnon have succeeded Professors Crum Brown and Taylor. A number of changes have also taken place on the staff of lecturers: Dr. Harold Pringle succeeds Dr. Herring, of lecturers: Dr. Harold Pringle succeeds Dr. Herring, Dr. Jolly succeeds Dr. Sutherland Simpson, Dr. Melville Dunlop succeeds Dr. Burn Murdoch, Dr. Marshall succeeds Dr. Arnott, and Dr. Alex. James succeeds Dr. Affleck. The principal structural changes have been in the direction of adapting to new purposes the rooms vacated by the Natural Philosophy and Engineering departments on their transference to the new laboratories in Infirmary Street. A much felt want has been met by the provision of a second examination room. The recataloguing of the library having ination room. The re-cataloguing of the library having been completed in 1906, and the alphabetical arrangement of the entries and insertion of the cross references being also practically complete, the question of the printing of the catalogue falls to be seriously considered. No funds are available, but perhaps some generous donor may be found willing to associate his name with this work.

### LETTERS TO THE EDITOR.

RHEUMATOID ARTHRITIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I am greatly indebted to the somewhat advanced "Student of Sixty" for his kindly remarks respecting my clinical lecture on this subject. I sincerely trust that if perchance he has not already passed his "Final," he will find it useful in that trying ordeal. He is evidently a man of great discernment, who has cultivated to their fullest energy his powers of observation, and I wish him well. I am afraid that the talk about "radio-activity" in certain natural hot springs is based on no solid foundation, and that it is but the outcome of a passing fancy. There is no doubt, how-ever, that much of the improvement seen in rheumatoid arthritis cases is due to the warmth of the climate and to basking for many hours a day in the bright sun-shine. The only question is where is it to be found in its fullest splendour. I know Aix-les-Bains well, and in summer it is hot enough in all conscience. For winter there is no place like Algiers, and Mustapha Superieur is an ideal health respecially if one can "cool off" by a few weeks spent at Hammam R'Irha, which is high and bracing, and where the sun ever shines. Then there are opportunities of availing oneself of the train de luxe on the Oran-Tunis line, and of visiting all kinds of quaint and interesting cities, changing, if my memory serves me, at El. Guerrah for Biskra, the desert outpost. Algiers has many advantages over Egypt, not only in accessibility, but in the cost of living.

Undoubtedly much depends on the nature of the soil, and sand or gravel are preferable to clay; but if there is a full south exposure, and the town is placed on the slope of a hill a clay subsoil is no disadvantage.

slope of a hill, a clay subsoil is no disadvantage. The great objection to our English health resorts is the expense necessarily incurred at anything like a decent or so-called first-class hotel. At many of these they refuse during the season to quote inclusive terms even for a prolonged stay, and 25s. a day is the average charge for room and board, even when that room is at the top of the house and of the size of a fairly capacious wardrobe. The wines, too, are atrociously dear, and of a want of character which is beneath contempt, whilst the cooking is pretentious and void of dis-

tinction. At the hotels at Aix-les-Bains good accommodation, good food, including decent red or white wine, can be obtained for from 15 to 18 francs a day, whilst in Algiers the same necessities can be secured for even less. Under the circumstances it is hardly surprising that many British patients, especially if travelling with their domestic belongings, prefer the Continental life. The increased cost of the journey is soon defraved by the reduced hotel bill. Possibly soon defrayed by the reduced hotel bill. Possibly when the English hotel keeper realises this, he may regain some of his lost customers.

I am, Sir, yours truly,
WILLIAM MURRELL.

January 8th, 1909.

THE APPENDIX: ITS USE, ABUSE, AND ITS CLAIMS FOR PROTECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I have only to-day seen a notice of Mr. C. B. Keetley's article to the Lancet in the Daily Mail of yesterday, and, whilst admiring his ingenuity and scientific suggestion—viz., that the appendix should be detached in certain cases where asepsis is within the bounds of possible permanent maintenance. the bounds of possible permanent maintenance, so that it may wander at will through the intricacies of the general peritoneal cavity, I fear it may not often be practical. This suggestion, admirable as it may be,

does not appear to me to be altogether practicable.

I also notice that a medical correspondent from the West London Hospital, in a contemporary, suggested that the appendix should be treated in a similar way to the gall-bladder-viz., by establishing an opening through the muscular layer of the abdominal wall, either temporary or permanent. No doubt in certain favourable cases the latter procedure is good surgery, and in competent hands excellent results have been chtained.

I would, however, humbly remark that when comments are made in the lay Press on any article taken from a medical paper, such as the Lancet, British Medical Journal or Medical Press, the language should be so simple as not to confuse the lay public with such terms as "appendicicostomy."

In these days of advertising of wonderful cures effected by patent medicines and manipulations, all doubtless containing a certain admixture of truth, it is most important that a noble profession like ours should keep itself clear. We never hear in the lay Press of the failure of these remedies or of these manipulations. On the other hand, we in publishing our statistics in our societies, or the medical papers, should, and do, I believe, publish our failures as well as our successes, for the good of the profession and the public who read them.

It was said many years ago by an eminent surgeon at a clinical lecture delivered at the London Hospital, that the chief use of the appendix being placed in the position which it occupies was to put fees into surgeons' pockets, and when the appendix boom was started in America it was even suggested in that great and progressive country that the appendix should be removed at birth or soon after, at the same time as vaccination, and in the case of the male child concurrently with circumcision when advisable.

I believe it was Knowsley Thornton who was the first

prominent surgeon to make the statement in this country that the gall-bladder in the normal state in a healthy man or woman during life should contain no bile, but had the power of secreting a peculiarly viscid mucus, which was controlled in the amount of the secretion and discharge by nerve action on the powerful muscular wall, to act so as to assist the passage of bile down the common duct.

Most of us have observed the inverted oil bottles, generally half-full of some special lubricating oil, placed at certain points of those magnificent engines of the boats plying between England and France, etc., and, in my humble opinion, the function of the appendix may be looked upon as acting at the junction of the large and small intestine as a special lubricator for the prevention of constipation, the most usual exciting cause of appendicitis, in the same way as the gall-bladder.

We are all too fond, or too apt in our own particular way, to make clean the outside of the cup and platter, whilst an overloaded inside is ravaged by the various bacillary wolves lying in wait at various spots along the tortuous canal, which measures at least 55ft. in length, and reduced into yards represents 1/95th part of a mile

May I close this letter by repeating the words of the late Sir William Jenner, delivered many years ago at the College of Physicians :-

'It is the duty of the physician (including, of course, the operating surgeon and the general practitioner) to prevent disease, and, failing that, to cure disease, and, failing that, to alleviate suffering and prolong life."

I am, Sir, yours truly,
WILLIAM ROSE.

10, Queen's Gardens, Lancaster Gate, W., January 5th, 1909.

#### PARENTS AND CHILDREN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. Sir,-Those who like myself invariably scrutinise your excellent paper from cover to cover are often rewarded by discovery of an interesting paragraph in outlying regions. This week, for example, on your last page, I find a reference to an article in a woman's magazine on "Modern Over-culture of Children." Parents, children, and doctors are nowadays all undergoing rapid character changes. The buxom mother, a picture of mental and physical health and happiness, surrounded by her brood of six to twelve bonny bairns, is becoming more and more rare; and the family doctor, the trusted confidential friend and adviser of the parents, knowing their history, and the history of everyone of their progeny intimately, is becoming equally difficult to find. The French fashion of limiting the children to two or three has made enormous strides among our well-to-do and wealthy classes within the past twenty years. Facts. regarding the falling birth-rate have been constantly commented upon in your pages. Not so much notice has been anywhere taken of the psychological effects upon both parents and children; they are none the less remarkable and interesting. When families were less remarkable and interesting. large the parents—the mother especially—had no time to closely watch the movements of the children; they were left much more to themselves, and to the experience and discipline which naturally developed among the small crowd. The mother's influence, neverthe-less, predominated; and where this was of the wholesome sort emanating from a woman of the sterling British type, the breed of physically fit was usually morally superior. Nowadays the two or three children are tied to the mother's apron string if she is devoted to them; or completely neglected and handed over to the care of servants, if she belong to the "smart set," that places the pursuit of pleasure as the supreme object in life. Every observant practitioner with ex-perience extending over the last 25 years must recognise the changing quality of the child and of the young man and woman of the day. The customs which have produced certain types in France, are producing like effects among our own people. A process of evolution is going on. But evolution does not connote necessarily the creation of a higher type; it may be merely better adapted to its environment. If that environment involves a moral atmosphere of pure egoism, the ultimate results surely must be disastrous.

I am, Sir, yours truly,
A YORKSHIRE PRACTITIONER.

Jan. 9th, 1909.

#### EXPERIMENTS ON PATIENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-My attention has been called to certain remarks with the above heading in your issue of January 6th last. In answer to the City Coroner's question as to the meaning of the words, "no experiments on patients," which is always printed on our reports, I

replied: -- "I should say it simply means exactly what it says-that there are no experiments-although, I suppose everything in treatment is in the nature of an experiment to a certain extent. In view of the fact that some people among the poor are very superstitious and shy of hospitals, I strongly advise every hospital to put the same words in their reports. They are of a reassuring nature. It means, practically no experiments, which are for the sake of knowledge, rather than for the good of the patients." And I concluded by reiterating my advice that other hospitals should adopt our custom. The last part of my reply is omitted from your paper. As far as "vivisection" (as defined by the 1876 Royal Commission) is concerned, no question of vivisection or anti-vivisection need necessarily come into experiments. You can experiment otherwise than for treatment without "vivisection."

If this Battersea General Hospital, quite apart from It this Battersea General Hospital, quite apart from any innuendo which hyper-sensitive persons may discover, and without any "quandary," as far as it is aware, thinks well to reassure those who, with or without actual evidence, are shy of entering a hospital, so that within its walls they may feel absolute confidence and safety, it has a perfect right to do so, without being absurdly and illogically told that it thereby asserts that there are no other hospitals where such appears are never indulged in; and that it stands experiments are never indulged in; and that it stands alone in this particular!

I am, Sir, yours truly, GEORGE W. F. ROBBINS, Secretary.

National Anti-Vivisection Hospital, Battersea Park, London, S.W., Tan. 8th, 1909.

[We publish the above as we do not wish to be thought unfair, and because we are content to leave the question to the judgment of impartial people.—ED.]

### VENTILATION OF RAILWAY CARRIAGES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—The question of the ventilation of railway carriages, I see you have considered deserving of attention among your articles on "Current Topics" in this week's MEDICAL PRESS AND CIRCULAR. It is one of those questions which belongs rather to that speciality which we recognise as sanitary engineering; for ventilation is hardly a subject which comes within the province of medical science. At the same time it is more than probable that sanitary engineering would not take up this subject unless it were forced upon it by the medical profession, and by our medical journals. You conclude your article in the following words: "The ventilation of railway carriages in winter depends primarily on adequate heating arrangements, and we cannot think how the public, year after year, allow the railway companies to flout their health and comfort with supercilious disdain."

A few years ago I made some observations on the air conditions of railway and other carriages, as their ventilation seemed to be misunderstood and neglected. Railway carriages and omnibuses are both unhealthy when at all overcrowded, and the means used to ventilate them show great ignorance. I will give you one instance of this which is constantly before us. on most of our lines a curious kind of double-pointed, small, chimney-top looking apparatus stuck on the roofs of most carriages, and when we are inside a carriage we at once associate these "ventilators" with the round openings we see over our heads. If we look closely into the way in which these ventilators work we must be surprised to see that some are set so that they point towards the engine, while some are set at right angles and point across the carriages. As I knew the theory on which this ventilator was constructed and patented, it certainly surprised me that any engineer could have brought out this article and that the railway engineers could have taken it up as they have done. The conclusion I came to was that railway engineers knew nothing about the science of ventilation, and that we need expect no improvements in the ventilation of railway carriages until this ignorance was replaced by some accurate and scientific study of the subject. What I learnt most from was experiments made with one of Casella's anemometers on the movements of the air inside railway carriages, when the windows were more or less open, and when the train was moving at slow or rapid pace. One thing certainly impressed me, and that was that those openings which we see just above the carriage windows, and which we can close or open by moving a slide that is made for the purpose, are of no use, for when I held the anemometer over these openings the fan wheel did not turn either way, and practically this arrangement was, and is, of no use. It sometimes amused me to see a passenger jump into a carriage and close the ventilator for fear of cold.

Some simple plan of warming carriages could easily be supplied by railway engineers; but ventilation is not such a simple matter, and I hope that your article will lead to this subject being treated with attention by the great railway companies, as it is to their advantage to study the comfort and health of their

passengers.

I am, Sir, yours truly, ROBERT LEE, M.D.Cantab.

Pwllheli, N. Wales, Jan. 9th, 1909.

### OBITUARY.

DR. ARGYLL ROBERTSON, OF EDINBURGH.

FROM a telegram received last week, we were made aware of the sudden death of this well-known oculist, at Gondal, in India. The unexpected end to his career in a distant country came as a sad shock to a wide circle of friends, for although Dr. Robertson had been in somewhat failing health for the past year, he was not known to be dangerously ill until the news of his death was received.

Douglas Moray Cooper Lamb Argyll Robertson was born in Edinburgh in 1837. He came of medical stock, for his father was a surgeon of high standing, and occupied the presidential chair of the Royal College of Surgeons immediately before Mr. Syme. Dr. Argyll Robertson was educated at Edinburgh and abroad; he

graduated M.D. at St. Andrews in 1857, and became a Fellow of the College of Surgeons in 1862. From the time he entered the medical profession he specialised in ophthalmology, being led thereto by the fact that his father, though not a specialist, had devoted much attention to eye diseases, and by the influence of v. Graefe, then at the height of his fame, under whom Dr. Argyll Robertson studied during his reise jahren in Germany. One of Dr. Robertson's first original discoveries in his speciality was made in conjunction with Sir Thomas Fraser on the properties of calabar bean, in which he found the agent he had long been seeking which was capable of causing myosis when applied locally to the eye. As a writer in "Quasi-Cursores"—the tercentenary festival volume of the University—says:—"A few years later (1869-70), he had again the good fortune to add another stone to his own cairn by associating his name with the eye symptoms in certain spinal lesions, and the 'Argyll Robertson pupil' is now as much a classic name as either Bright's disease or Pott's fracture." In 1870 he was appointed ophthalmic surgeon to the Royal Infirmary, and remained on the acting staff until 1897, when, on his retirement, he was appointed Consulting Surgeon. He was also Honorary Lecturer on Ophthal-mology, and held numerous other honorary appoint-ments in Edinburgh, notably those of Ophthalmic Surgeon to the Blind Asylum and to the Sick Children's Hospital.

Dr. Argyll Robertson was an ardent follower of every form of manly sport, in which his fine physique every form of many sport, in which his his physical enabled him easily to excel. He was one of the leading amateur golfers of his day, winning the gold medal of the Royal and Ancient Club five times, and the silver cross twice. He was also a member of the Royal Archers-the Royal Bodyguard for Scotland. Next to golf, travel was his chief recreation. He had already visited Japan and India, and it was on his return to the latter country, on a visit to the Thakore Sahib of Gondal, that he died.

Among the numerous honours which Dr. Argyll Robertson's high position in the profession brought on him the following may be mentioned:—Honorary Surgeon Oculist to the King, President of the Ophthalmological Society of the United Kingdom, of the International Ophthalmological Congress, 1894, of the Edinburgh Medico-Chirurgical Society, of the Royal College of Surgeons; member of the Ophthalmic Society of Heidelberg, Corresponding Fellow of the New York Academy of Medicine, Honorary Member of the Neurological Society of New York, Foreign Associate of the Society of Physicians of Prague. In 1896 he received the degree of LL.D. from the University of Edinburgh. Dr. Argyll Robertson married, in 1882, a daughter of Mr. Fraser, of Tomavein and Findrach; he had no family. On his giving up practice in Edinburgh in 1904, he and his wife removed to Jersey—a step which was regretted by the large circle of friends who owed so much to the hospitality of Dr. and Mrs. Robertson. At that time he was presented by his colleagues with a portrait by Sir George Reid, R.S.A., and a replica was hung in the College of Surgeons.

### DR. ALEXANDER PATTERSON, OF GLASGOW.

Dr. ALEXANDER PATTERSON, an eminent Glasgow surgeon, died on January 5th, at Draperstown, Ireland, his native place, to which he retired a short time since when relinquishing practice in Glasgow. Dr. Patterson graduated M.D. of Glasgow University in 1854, where he proved himself an apt and successful student. In 1860 he became F.R.C.S.Ed., and in 1869 a Fellow of the Faculty of Physicians and Surgeons, Glasgow. Soon after graduation, he started practice in the east end of Glasgow, and in 1868 was appointed Dispensary Surgeon to the Royal Infirmary. He became Surgeon to the Lock Hospital in 1872. When the Western Infirmary was opened, a deputation of the managers waited on him and asked him to become one of the surgeons. Dr. Patterson was recognised as the most dexterous surgeon in Glasgow in his day, operating with equal facility with either hand, and an enormous amount of surgical work passed through his hands. He held it to be impossible to overcrowd his wards, as he insisted on the windows being kept freely open night and day, and patients before they got accustomed to this mode of life used to grumble a good deal. He was thus a pioneer in the fresh air treatment of disease, and his results compared most favourably with those of his colleagues. Nay, he told the writer that patients coming into his wards with old bronchitic What he coughs frequently left cured of their cough. practised in the hospital, he practised at home, for his bedroom window was raised at the bottom nearly a foot and had never been shut for twenty years, except by window cleaners. He regarded oxygen as the best of all tonics. He early adopted Lister's treatment and practised it most successfully. There was no safer surgeon than Dr. Patterson. He was a man of rare sagacity, and he diagnosed a case promptly. He had great faith in the use of the cautery for white swelling in the knee-joint, coupled with an iron splint, with a raised U-shaped curve to allow dressings to be applied. He taught that both tubercle and cancer were local expressions of constitutional states, and that measures to raise the vitality of the patient were as necessary as surgical operations. He had a large experience of syphilis and considered it a disease that was very seldom completely eradicated, having known local manifestations of it thirty years after infection. In phagedænic sores, he gave half to one grain of opium every four hours, a practice also recommended by Erichsen, and which appears to act like a charm, when conjoined with cleanliness.

Dr. Patterson was a faithful observer of Nature, and made many acute and original observations. He was the first to cut down on the kidney and remove a stone from its pelvis. He tells how he was a little nervous, lest hæmorrhage should be troublesome. He had great faith in putting diseased parts at rest, by splints or otherwise, and insisting on free and thorough drainage. He was a man of rare surgical wisdom and instinct, and was often called in consultation with colleagues; but he was more than a great and successful surgeon, holding strong Christian principles, by which he en-tirely subordinated worldly honours and emoluments to his firm conviction of Biblical truth.

DAVID THOMAS CADVAN JONES, M.B. THE death is announced of Dr. David Thomas Cadvan Jones, Colwyn Bay, at the age of 33 years. The son of the late Rev. Cadvan Jones, Congregational minister, Carmarthen, he was educated at Caterham Congregational College and Aberystwyth University College, and took his M.B. degree at University College, London. His first practice was at St. Leonardson-Sea, which he relinquished in order to remove to Colwyn Bay, where he resided for four years with his mother and two sisters. Dr. Jones was one of the most popular and useful members of the Colwyn Bay National Eisteddfod Committee.

### DR. REGINALD ROBERT WHISHAW, B.A., M.B., F.R.C.S.

WE regret to learn that Dr. R. R. Whishaw died at Willowburn, Queensland, on December 10th from an accident, at the early age of 46.

Dr. Whishaw studied at the University of Cambridge and St. Thomas's Hospital. At the University he obtained the B.A., M.B., and B.C. degrees, whilst in London he qualified for the Fellowship of the Royal College of Surgeons and as a licentiate of the Royal College of Physicians. In medical appointments, Dr. Whishaw had a wide experience, for at various times he held the following posts:—House Physician to the Brompton Consumption Hospital, Surgeon to Croydon Hospital, Demonstrator of Anatomy at the Medical Schools of Cambridge and Bristol, House Surgeon to the Liverpool Children's Hospital, and Secretary of the London and Counties Medical Protection Society. Dr. Whishaw subsequently practised in Tasmania, whilst at the time of his death he was medical superintendent of the Hospital for the Insane at Willowburn, Queens-

ELIZA M. CURRIE-SMITH, M.B., B.S.Lond. WE regret to announce the death of Miss Eliza M. Currie-Smith, M.B., B.S.Lond., who was appointed in February last to the post of Junior Assistant Medical Superintendent at St. Pancras Workhouse Infirmary. She died at that institution on Tuesday last, after a few weeks' illness. She was trained at the Royal Free Hospital. Patients, nursing staff, and medical officers will long retain recollection of her charming personality and kindly disposition. Among the wreaths was one from the infirmary patients, who subscribed their pence as a token of affection and esteem for the departed officer.

### REVIEWS OF BOOKS.

CLINICAL BACTERIOLOGY. (a) Wz welcome the appearance of a new edition of this admirable work. It is only some two years since the last edition was published. The book is specially designed for the use of the general practitioner, and is divided into two distinct sections. The first of these deals with bacteriological technique, and contains one of the simplest accounts of this subject with which we are acquainted. Not only does the author supply his readers with the information necessary to carry out the various processes, such as staining and mounting films and sections, but he also shows how to apply the results obtained in making a diagnosis. The very lucid and accurate account given of the preparation

<sup>(</sup>a) "Clinical Bacteriology and Hæmatology for Practitioners." By W. D'Este Emery, M.D., B.Sc. Lond., Clinical Pathologist to King's College Hospital and Pathologist to the Children's Hospital, Paddington Green. Third edition, London: H. K. Lewis. 1908. Price 7s. 6d. net.

of culture media is a special feature, and at the same time the mode of developing the cultures themselves is fully and clearly explained. In the section devoted to hæmatology, which is much the shorter of the two, a sufficiently complete and practical account is supplied of the methods adopted in these days for the investigation of diseases of the blood. A brief description of the mode of preparation of bacterial vaccines has been added to this edition. Fuller details are now given regarding the diagnostic method of lumbar Some of the coloured plates have been redrawn, and one or two new figures inserted in the text. The book, as it now stands, is one of the best guides on clinical bacteriology and hæmatology that the practitioner can have. Throughout its pages he will find the solution of many difficulties which crop up in the course of one's private work in connection with these subjects.

CLINICAL LECTURES ON NEURASTHENIA. (a) NEURASTHENIA is unquestionably receiving more attention and occupying a larger place in works on systematic medicine than it did-doubtless owing to the fact that its ætiology and treatment are now better understood. To the author, we believe, belongs the credit of first pointing out, in 1898, that a large proportion of cases of neurasthenia—probably 75 per cent.—are due to a toxemia of some kind; indeed, the reason why these cases have so often been regarded as incurable is the difficulty of discovering the particular

toxemia in operation for purposes of treatment.

The author's view is that in a large proportion of the cases the toxemia is of gastro-intestinal origin, though the symptoms are often so obscure as to escape recognition. The existence of a psychic element, however, is not overlooked—in fact, a new chapter has been added dealing more particularly with the psychology and the psychotherapy of the disease. This strikes us as one of the best chapters in the book, for the author handles the subject sympathetically, and gives some very useful advice concerning the difficulties encountered in dealing with these patients, and how best to cope with them.

The fact that a fourth edition has been called for at so short an interval is evidence that the subject is one of general interest, and we know of no better guide to its diagnosis and treatment than Dr. Savill's masterly

### MEDICAL NEWS IN BRIEF.

### University of Lenden.—The Medical Unit in the Army.

THE Military Education Committee appointed by the Senate on December 16th to manage the University Contingent of the Officers' Training Corps, have received the reply from the War Office to the offer of the University to furnish a contingent of the Officers' Training Corps. The Army Council have sanctioned Training Corps. The Army Council have sanctioned the formation of a contingent which shall include an infantry, an engineer, and a medical unit, these units being composed of three companies of infantry, one company of engineers, and two sections of a field ambulance respectively. It is expected that additional companies will be formed at a later date, subject to the sanction of the Army Council. The rules for the contingent provide that admission to the contingent shall be restricted to gentlemen who are members of the University of London, or are non-matriculated students pursuing a regular course in schools of the University, save that, subject to such regulations, if any, as may be prescribed by the Military Education Committee, power is reserved to the Commanding Officer in special cases to admit gentlemen who, though not comprised in either of the foregoing categories, are desirous of gaining the certificates of proficiency obtainable in the Officers' Training Corps The Corps is intended for the preliminary training of young men with a view to their qualifying for commissions in the

Special Reserve of Officers, or the Territorial Force, and membership of the corps is restricted by the Army Council to British subjects of pure European descent. The members of the medical unit will be drawn from the medical schools attached to the University, more than a hundred students from Guy's, St. Bartholomew's, St. Thomas's, University College, King's. College, and other medical schools naving already applied for membership. Enrolment in the contingent was to begin immediately after the Christmas vacation. With regard to headquarters, no arrangements have yet been made, and the training will be carried out, for the present, in the colleges attached to the University.

#### The Allegations Against a Middlesbrough Medical Man.

The Allegations Against a Middlesbrough Medical Man.

THE adjourned inquest on Amy Arnold (25), single woman, of Smeadon Street, North Ormesby, Middlesbrough, was resumed at North Ormesby on January 6th. At a previous inquiry grave allegations. were made against a well-known Middlesbrough medical practitioner. The girl Arnold died at North Ormesby Hospital on December 3rd, following an alleged illegal operation. At a previous inquiry the medical gentleman against whom the allegations were made gave evidence, stating that he did not remember made gave evidence, stating that he did not remember any one of the name or description of the girl having called upon him, and said that practically all the state ments made against him were untrue. He also denied the truth of statements made to the doctors in the hospital by deceased. The adjournment was for the purpose of submitting to the public analyst a quantity of medicine found at deceased's home.

The Coroner (Mr. O. H. Cochrane) said he did not propose to take any further evidence that day. There was a lot of additional evidence to be gone through. Dr. Falconer, who was present at the death of Arnold, had unfortunately been called away to the funeral of a relative, and, taking that into consideration, he thought it best to adjourn the inquest to some future

### Accommodation for Infectious Cases at Bootle.

AT a recent Council meeting at Bootle, Alderman Cain, Chairman of Bootle Health Committee, proposed, "That the terms offered by the Liverpool Corporation for the admission of small-pox cases from Bootle into the Liverpool City Hospital at Fazakerley be not accepted, and that the scheme for the establishment of a small-pox hospital, approved on February 5th, 1908, be proceeded with." He stated that, following upon the Local Government Board inquiry into the matter, a communication was sent to the Health Committee asking them to try and make some arrangement with the Liverpool Corporation to take in their small-pox cases. This had been done, but the charges which Liverpool made were so exorbitant that the Health Committee could not recommend them tothe Council for their acceptance. The committee, therefore, wanted to go on with their former scheme, which had not been refused by the Local Government Board. If the consent of the latter was not granted, Bootle would have to pay at once an annual sum of £500 to the Liverpool Corporation whether there were any patients from Bootle in their hospital or not.

Dr. Wild seconded, and said it was absolutely necessary that they should have some extra accommodation for small-pox. The expense would be very little at

Dr. Rafter protested, on behalf of the public, against the proposed erection of a new infectious hospital, and maintained that it was not required.

Dr. Turner moved as an amendment that the schemebe put back for further consideration. His principal reason for this, he said, was absolutely one of economy.

Alderman Ascroft said there would be a great outcry in the town if the scheme was carried out.

Alderman Cain said he would like to know what the people of Bootle would think if, when a severe epidemic of small-pox occurred, the health authorities were to send all the scarlet fever patients to their homes in order to make room for the small-pox cases

at the present infectious hospital.

The amendment was carried.

<sup>(</sup>a) "Chinical Lectures on Neurasthenia," By Thos. D. Savill' M.D.Lood., Physician to the West End Hospital for Diseases of the Neurous System, &c., &c. Fourth edition. London: H. J. Glaisher. 1908, Price 7s, 6d. net.

#### Consumption In Dundee.

A PROPOSAL has been made and inquiries instituted thereanent for the Corporation of Dundee taking steps for thoroughly dealing with the subject of consumption. The importance of dealing with the disease has been emphasised, and the time has now arrived, in the opinion of several members of the Council, for seriously tackling the subject. The opinion in the country is in favour of making consumption a com-pulsorily notifiable disease. The idea in the minds of certain members of the Town Council is that the Sanatorium at Auchterhouse should become a Corporation institution. Meantime, inquiries are being prosecuted, and a visit is to be made on behalf of the Public Health Department to obtain data on which future proceedings may be based. The Sanatorium at Auchterhouse, it may be mentioned, occupies a site at the base of the Sidlaws. Founded by the generosity of the late ex-Provost Moncur, its present dimensions and development exceed expectations. In 1899 he gave a sum of £10,000 for the purpose, but this was subsequently found to be insufficient to meet requirements, and Mr. Moncur at various times increased the amount of his gift until the total reached about £25,000. It was opened on September 26th, 1902. Much good work has been done through the agency of the institu-tion, but it has always been found difficult to make the revenue from patients' board and contributions from private sources meet the cost of maintenance.

#### Old-Age Pensions and Infirmary Patients.

THE Local Government Board, Ireland, have informed the Letterkenny Guardians that old-age pensions are inalienable, and that, therefore, they cannot be taken by Guardians to pay for the cost of the maintenance of the pensioners in a workhouse infirmary.

#### The Irish Medical Association.

AT the last meeting of the Council of the Irish Medical Association a circular recently issued by the Registrar-General to Registrars of Births and Deaths in Ireland was under consideration. This circular requests Registrars to send to the pension authorities a weekly return of the deaths of all persons aged 70 years and upwards. A fee of two pence is to be paid for each return, in addition to a fee of two pence for every death entered in a return. We understand that a memorial has been sent to the Lords Commissioners of the Treasury praying for adequate remuneration, failing which the Registrars may have to consider whether they can continue to act in that capacity under the present conditions. The Council of the Association adopted the following resolution:-

That the Council of the Irish Medical Association. beg to inform the medical profession in Ireland that there is no statutory duty cast on them in regard to signing certificates as to the inability of pensioners to attend at post-offices for the purpose of receiving payment of their pensions.

"The Council are also of opinion that members of the medical profession signing certificates in connection with the Old-Age Pension Act should be remunerated by the Treasury.

### Notili ation of Tuberculosis.

An interesting announcement came at the end of the business of the Sanitary Committee at Middles-brough on January 5th, when Dr. Dingle stated that he had already received 29 notifications of tuberculosis in accordance with the new order. These were from Poor-law sources, so that the number which may be notified in due course will probably be very much larger, and, being notified, it now rests with the Sanitary Committee to take what steps they may think fit to safeguard the healthy portion of the community against the unhealthy. There is bound to be some additional cost, but, as one councillor remarked, it is in the interest of the public at large that measures of some kind should be taken.

It is not surprising that the severe weather conditions recently experienced throughout the United', Kingdom should have produced an immediate effect on the death-rate, especially among the aged and the

feeble. The rates of mortality, which had been as low as 12.8 per 1,000 of the population in the large towns, rose to an average of 18.2, and in some cities to as high a figure as 24 and 30. Measured by last week's mortality, the highest annual death-rates per 1,000 living were: From all causes, 23.3 in Wigan, 23.4 in Oldham, 23.5 in Liverpool, 24.1 in Sunderland, 25.1 in Coventry, and 30.4 in Merthyr Tydfil; from measles, 2.9 in Great Yarmouth and in Rochdale, 3.0 in West Ham and in Middlesbrough, and 6.3 in Leicester; from diphtheria, 1.1 in East Ham and in Salford, 1.3 in Kings Norton and in Birkenhead, and 1.9 in Devonport; from whooping-cough, 1.1 in Swansea and 1.5 in Wolverhampton; from "fever," 1.5 in Warrington; and from diarrhœa, 1.6 in Walsall. No death from small-pox was registered in any part of the United Kingdom.

#### Infant Mortality.

At a meeting of the executive committee of the National Conference on Infant Mortality, held at the Westminster Palace Hotel on Jan. 8th, at which Councillor Anderson, of Glasgow, occupied the chair, and representatives of medical officers from all parts of the country were present, it was stated that the Prime Minister had agreed to receive a deputation to consider further resolutions which had been approved by the members of the conference.

Reports of the conference's deliberations in 1906 and 1908 are to be printed, so that local authorities in various parts of the country may be supplied with them, and the meeting approved the steps which had been taken in regard to certain clauses in the Children's

The conference tendered its thanks to the Parliamentary Committee, of which Lord Robert Cecil, the Hon. Alfred Lyttelton, and Mr. Arthur Sherwell are prominent members.

#### Nottingham City Council and Consumption.

A discussion introduced by Drs. A. Fulton and P. Boobbyer on the attitude of the municipality to the treatment of phthisis (consumption) took place at a meeting of the Nottingham Medico-Chirurgical Society last week, and it was decided by a practically unanimous vote of the members that in view of phthisis being an infective and communicable disease, dangerous to the public health, voluntary or compulsory notification of cases of it to the sanitary authority should be adopted forthwith.

### University of London.

THE following candidates passed the M.D. Examination during December, 1908:—
Branch I. (Medicine).—Henry H. Bashford, B.S.; Dorothy C. Hare, B.S.; Conwy Ll. Morgan, B.S.; John M. O'Meara, B.S.; William M. Sadler, B.S. (University Medal); William O. Sankey, B.S.; William L. Scott, B.S.; Charles A. Stidston, B.S.; Thomas M. Tibbetts; Ivy E. Woodward, B.S. (obtained the number of marks qualifying for the University Medal) University Medal).
Branch II. (Pathology).—Oskar C. Gruner (Univer-

sity Medal).

Branch IV. (Midwifery and Diseases of Women).-Frank Alcock, B.S.; David H. de Souza, B:S., D.Sc.; Robert A. Hendry, B.S. (University Medal); Ethel F. Iredell, B.A.; Clifford A. L. Mayer, B.S.; Alan Randle, B.S.

Branch V. (State Medicine).—Barbara Tchaykovsky,

B.S., B.Sc.
Branch VI. (Tropical Medicine).—Harold R. Nutt;
Oswald Marriott, B.S.

The following passed the M.S. Examination:--Walter R. Battye, B.Sc.; Athelstan J. Blaxland; Clifford A. Moore; Henry J. Nightingale (University Medal); Harold B. Whitehouse (obtained the number of marks qualifying for the University Medal).

THE Secretaries of the Conolly Norman Memorial Committee desire to remind intending subscribers that the list will be closed on January 31st. Subscriptions will be received by W. R. Dawson, M.D., Farnham House, Finglas, Co. Dublin, or J. R. O'Connell, M.A., LL.D., 34, Kildare Street, Dublin, Treasurers.

### **NOTICES TO** CORRESPONDENTS, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Institut, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule. SUBSCRIPTIONS.

SUBSCRIPTIONS.

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insertion; £6. per line beyond.

MISSING THE BOOK AND SYRDINGS.

KISSING THE BOOK AND SYPHILIS

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Dear Sir.—I hope you have read the letter of Colonel Mapleson on page 6 of last Saturday's Times and also its leader of Monday. My difficulty has always been to prove a specific case of infection from this cause. I have seen the book kissed by witnesses suffering from constitutional syphilis, and it would be very difficult to prove infection. Colonel Mapleson has clearly proved that disease may be conveyed, and it is a matter for the medical profession to follow up.

I am, Sir, yours truly,

40. Knight Street Liverpool.

40, Knight Street, Liverpool, January 9th.

Ex Uno Disce Omnes.—A course of post-graduate instruction would probably meet our correspondent's requirements. Full information respecting the post-graduate tuition in London will be found in our Students' No., published in September last.

THE PAYMENT OF MIDWIFERY FEES BY BOARDS OF GUARDIANS.

GUARDIANS.

DR. S. G. TIPPETT.—The paragraph on Nov. 18th to which you refer was founded on a statement by a responsible law journal, which, however, is not quite accurate. We have referred the matter to the central authorities, and find the only circular note issued to Guardians on the point was that of July 20th, 1908. If the District Medical Officer attends a labour when called by a midwife, he is entitled to payment should the woman be actually in receipt of relief, or should the Guardians subsequently decide that she was in a destitute condition, although no order for his attendance was given by a person qualified to make such order. The L.G.B. have decided that under the Act it is competent to pay the fee of any medical man called in on the advice of a midwife. The L.G.B. further advise Guardians to fix a definite scale of remuneration, and to exercise their powers for payment of medical men in their Unions in cases where the patient is too poor to pay the medical fee. It must be noted, however, that such action on the part of Guardians is voluntary, except in the case of District Medical Officers.

Schultzon (Barnstaple).—We have referred the query to an expert Radiographer, from whom a private note will be received by our correspondent.

A CONSCIENTIOUS BURGLAR AND HOSPITALS.

A CONSCIENTIOUS BURGLAR AND HOSPITALS.

A burgler, after breaking into the offices, last week, of the Richmond Athletic Asociation and ransacking the place, including a hospital box, left the following note:—

"As this is hospital money I am afraid to touch it. I don't wish to rob hospitals.—Yours truly, A Burglar."

### Meetings of the Societies, Tectures. &c.

WEETINGS OF THE SOCIEITES. THE WEETINGS OF THE SOCIEITES.

WEETINGS OF THE SOCIEITES. THE WEETINGS OF THE SOCIETY (LONdon Institution, Finsbury Circus, E.C.).—8.50 p.m.: Mr. Bland-Sutton: Thrombosis and Embolism after Operations on the Female Pelvic Organs.

NORTH-EAST LOYDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

THURSDAT, JANUARY 14TH.

ROTAL SOCIETY OF MEDICINE (UBSTETRICAL AND GYNECOLOGICAL SECTION) (20, Hanover Square, W.).—7.45 p.m. Short Communications: Mrs. Florence E. Willey; Mrs. Stanley Boyd. Paper; Dr. R. H. Paramore. Specimens: Mr. E. W. Hey Groves; Dr. A. H. N. Lewers; Miss Gairett Anderson; Dr. Macnaughton-Jones.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynrecological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X. Rays. 3 p.m.; Medical In-patient (Dr. G. P. Chappel). 5 p.m.: Demonstration: Dr. E. J. Squire, C.B.: Pulmonary Tuberculosis in Children (at the Mount Vernon Hospital, Hampstead).

HOSPITAL FOR SICK CHILDREN (UNIVERSITY OF LONDON) (Great Ormond Street, W.C.).—4 p.m.: Lecture: Mr. A. Lane: Fractures in Children.

FRIDAT, JANUARY 15TH.

ROTAL SOCIETY OF MEDICINE (ELECTRO-THERAPEUTICAL SECTION):
(20, Hanover Square, W.).—8.50 p.m.: Discussion: On the Value of X Bays in Discases of the Digestive System, to be opened by Dr. A. E. Barclay, followed by Dr. Thurstan Holland, Dr. G. A. P'Irie, and others. FRIDAY, JANUARY 15TH.

### Appointments.

CROWTHER, SIGNET NELSON, M.R.C.S., L.R.C.P.Lond., Senior Assistant Medical Officer at the Surrey County Asylum, Netherne, near Merstham.

HALL, OCTAVIUS, D.P.H., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Lecturer in Hygiene at the Devonport Municipal Science, Art, and Technical College.

HANNA, H., M.A., B.Sc., B.C.h.R.U.I., Assistant Surgeon to the Ulster Eye, Ear, and Throat Hospital, Belfast.

HICKS, J. A. BRAXTON, M.B., B.S.Lond., Senior House Surgeon at the Branch Seamen's Hospital, Royal Albert Docks.

HUTTON, HENRY RICKMOND, M.A., M.B.Cantab., Lecturer on Diseases of Children in the University of Manchester, and Physician to the St. Mary's Hospitale, Manchester, LUKE, THOMAS, D., M.D., F.R.C.S.Ed., Physician and Medical Superintendent to the Peebles Hydropathic, Peebles, N.B.

### Vacancies.

Cancer Hospital
Assistants.
(See advt.).

Notts County
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Asplications to Fred W. Howell, Secretary.
Medical Suprintendent.
Salary, £600 per annum, with unfurnished house, cosl, light, washing and garden produce.
Applications to John Frederick Gell, Clerk to the Visiting ommitttee.

Rotherham Hospital and Dispensary.—Senior House Surgeon.
Salary, £110 per annum, with rooms, commons, and washing.
Applications to the Secretary, H. Kelson, Masonic Buildings,
High Street. Rotherham.

Applications to the Secretary, H. Kelson, Masonic Buildings-High Street, Rotherhsm.

East Dispensary, Bath.—Resident Medical Practitioner. Salary, £130 a year, with furnished apartmente, coals, gas, and domestic attendance Applications to the Honorary Secretary, 6, Bathwick Hill, Bath.

National Sanatorium Association.—Secretary Steward. Salary, £156 per annum. Applications to A. W. West, 3, Lyali Street, Belgrave Square, W.

London Fever Hospitai, Liverpool Road N.—Assistant Resident Medical Officer. £150 per annum, with residence and board. Applications to the Secretary.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician. Applications to the Secretary. Salary £30, washing allowance £2 10s., with board and residence in the Hospital. (See advert.)

Northampton General Hospital.—Senior Resident Medical Officer. Salary, £120 a year. Apartments, with board, washing, and attendance. Applications to C. S. Risbee, Secretary.

Birmingham General Dispensary.—Resident Surgeons. Applica-

Birmingham General Dispensary.—Resident Surgeons. Applica-tions to Ernest W. Forrest, Secretary. Salary, £170 per annum, with furnished rooms, fire, lights, and attendance.

### Births.

FIN.—On Jan. 9th, at Simla, Kildare, Ireland, the wife of Capt. A. W. A. Irwin, R.A.M.C., of a son cox.—On Jan. 5th, at Montrose House, Clifton, Bristol, the wife of Stuart Vernon Stock, F.B.C.S., of a daughter.

BB.—On Jan. 7th, at Kingsbridge, South Devon, the wife of William Webb, M.D., of a daughter.

### Marriages

SHEBLOCK—GALE.—On Jan. 4th, at Christ Church, Sutton, Edward Birchall Sherlock, M.D., B.Sc. (Lond.), Barrister-at-law of the Middle Temple, eldest son of Mr. and Mrs. Thomas Sherlock, of Redwood, St. Helen's, Lancs., to Phyllis Courtenay, third daughter of the Rev. Courtenay and Mrs. Gale, of Christ Church Vicarage, Sutton.

### Beaths.

BARNEWALL.—On Jan. 4th, at Ashcombe, Harrogate. Brigadesurgeon Lieut.-Colonel T. T. Barnewall, late A.M.S. and
Rife Brigade, J.P., Co., Dublin. R.I.P.

HARLAND.—On Jan. 9th, at a private nursing home in London,
in his 37th year, William Henry Harland, M.R.C.S., L.R.C.P.,
of Sandy Knap, East Cowes, I.W., late civil surgeon, 17th
Lancers, Boer War, Captain R.A.M.C., Territorials; son of
the late R. T. Harland, of Hele, Cheslire.

KILLBY.—On Jan. 9th, at 152 Highbury New Park, Thomas A
KIIIDA, M.R.C.S., L.R.C.P., aged 28.

POWER.—On Jan. 8th, at 12, Stanley Place, Leamington, and
daughter of the late Charles Wake, M.D., of Warwick, in
her 93th year.

SEDDON.—On Jan. 2nd, at Yew Lodge, Bromley, Kent, Hugh
Bonvil Seddon, M.R.C.S., L.R.C.P., aged 42, son of the late
John Pollard Seddon, F.R.I.B.A.

WHISHAW.—On Dec. 10th, at Willowburn, Queensland, Australia,
auddenly, the result of an accident, Reginald Robert
Whishaw, B.A., M.B.Cantab, F.R.C.S.Eng., aged 46.

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# THE MEDICAL PRESS AND CIRCULAR

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, JANUARY 20, 1909.

No. 3

### Notes and Comments.

The to comment on the Report of the Inebriates' Act Home Office Committee on the Report. Inebriates' Act, in spite of the fact that it was issued only a few

Inebriates' Act, in spite of the fact that it was issued only a few going to press. The importance of hours before going to press. the recommendations contained therein is great, and we revert to the subject again to-day in a second leader. Temperance reform is still in a transition state, and medical men, who probably see more of the havoc wrought by alcohol than any other class of the community, will watch the evolution of legislative control with especial interest. The question is surrounded with doubts and difficulties, but it hardly requires the sanguine views of a confirmed optimist to inspire one with the firm and assured confidence that they will sooner or later be overcome. The day has long gone by when it could be seriously argued that to attempt to control the chronic drunkard would be to interfere unduly with the liberty of the subject. The fact of the matter appears to be that the inebriate requires control in the interests both of himself and of other folk just as much as does the lunatic. Our compulsory powers of dealing with the early stages of insanity are notably defective. It is often not until the general paralytic has committed some criminal act that his career of violence or of spendthrift dissi-pation is brought to an end. By that time his fortune has in many cases been flung to the four winds of heaven, and his relatives are deprived of their legitimate expectations.

The Parallel of Insanity.

THE need of control of insanity, especially in the early stages of general paralysis, is only too evident. It is not a whit less necessary in the case of early inebriety. The craying for

of early inebriety. The craving for strong drink, indeed, so far as that goes, is in many symptomatic of a weak moral control, and in its later stages, when organic changes have taken place, it becomes to all practical intents a kind of insanity. From a scientific point of view, it therefore seems that there is a good deal of ground for applying compulsorily a similar degree of restraint to the lunatic and to the confirmed drunkard. The case of Jane Cakebread, with her hundreds of convictions for drunkenness, is often quoted as illustrating the futility of punishment in reforming an offender of that kind. No one, however, who has read the narrative of Mr. Holmes, the police court missionary, can doubt for a moment the in-sanity of that poor woman. The Departmental Committee has taken a strong attitude. When mild measures have failed, they advise the Draconian method of indefinite detention, just as in the case of lunatics, only that every three years there is to be a sort of revision or right of appeal in each individual

case. It need hardly be remarked that such a course would require most stringent safeguards against abuse by relatives or others who might wish to apply such powers to their own selfish ends. In any case, public opinion may be trusted to determine to what extent inebriety shall be controlled in the interests of the community. Clearly something more is wanted than our present happy-go-lucky methods.

Notification of Cancer.

Notification is in the air, and many good people seem to consider that the way to scotch an infectious disease is to notify it, as though the shame of publicity would cause the

offender to obtrude itself less boldly. It is, alas! difficult to say of any disease compulsorily notifiable that it has diminished, either as the result of the notification or the measures following thereupon, but, no doubt, notification supplies interesting material for statistical study. At a recent meeting of the Malmesbury Board of Guardians, a letter was read from the neighbouring Board of Mere, asking the former to join them in applying to the Local Government Board to order cancer to be scheduled as a disease for notification under the Infectious Diseases Notification Act, and, after discussion, the Malmesbury Board decided unanimously to support their brethren in the request. While commending this zeal for hygienic measures in bodies not constituted for public health purposes, we are puzzled to understand how cancer, in the present dubious state of its pathology, could be legally regarded as a dangerous infectious disease, and, still more so, how notification would allay its progress. Doubtless, in days to come, when society is organised on ultra-Teutonic lines, we may find every case of nasal catarrh notified as being infectious, but at present the proposal to notify cancer seems rather prema-

Bermondsey Bath Water. An interesting experiment has been carried out by the Bermondsey Borough Council. Finding that water for their public baths cost high, they conceived the idea of using the

same bath water over and over again; but, let us hasten to add, after a process of purification had been gone through. The "washed water," as it is called, has been analysed both chemically and bacteriologically, and is declared to be above the average of waters supplied to baths generally. Dr. Eyre, the bacteriologist, declared the filtered water resembled the water of a new-filled bath, although it had been in the bath ten months, and Dr. Brown, the medical officer of health, says, in his opinion, the water chemically shows a great improvement over that previously used, and he considers the

system has come up to all expectations. The charge for water has fallen from £243 per annum to £5 17s., and, even with all the expenses of the new system, the cost only amounts to £174 18s. 4d. Now all this may be so, and it is good to save money and to advance the science of public bathing at the same time. But the £70 a year saved is purchased at the cost of sentiment, to which mankind is prone, and to which, in this case, we are rather apt to incline ourselves. It may be comforting to know the "washed water" is the latest triumph of science, and that its bacteria per c.c. are low as compared with the Thames or the Lea, but it is not so reassuring to the swimmer who gets a "mouthful" suddenly to realise that 2,657 Bermondsey lads have already bathed in that same water.

Catch 'em Alive.

WE have before referred to the odd notion possessed by a certain sect of amateur pathologists that acute diseases are safety-valves which prevent communities becoming the prey

of chronic ones. A letter contributed to the Daily Express of the 13th inst. seems to express this view with so much naïveté as to be worth reproducing entire:-

Measles.

To the Editor of the Express.

Sir,—Measles! What is it? Scarlet fever!
What is it? Infectious! Then how does the first child get it? May I astonish your readers by saying that these things instead of being calculations. ing that these things, instead of being calamities, are signs of vitality? Why, it would be well for England if half her sons were down with fever Why have we almost no fevers? to-day. have chronic diseases taken their places? These are the questions for patriots to answer. Will someone try to explain these difficulties?

J. P. SANDLANDS.

Brigstock, Thrapston.

The interest of lucubrations of this type lies in the fact that-in medicine, at any rate-there is no selfevident or palpable absurdity which does not find a serious coterie to support or believe in it. The idea of this grotesque letter seems to be the same as that which still widely prevails among the poor, namely, that if a rash is cured the disease is "driven in."

### LEADING ARTICLES.

THE REPORT OF THE COMMITTEE ON THE INEBRIATES' ACTS.

[SECOND NOTICE.]

In our last issue we gave a summary of the above Report, which was made public on the evening before we went to press. More leisurely consideration shows that no point of importance was omitted in that summary, but certain features of that important document appear to us to demand treatment at greater length than was possible at so short a notice. The first of these is the definition. The definition of habitual drunkard in the Habitual Drunkards' Act, 1879. is as follows:-" Habitual drunkard means a person who, not being amenable to any jurisdiction in lunacy, is, notwithstanding, by reason of habitual intemperate drinking of intoxicating liquor, at times dangerous to himself or herself or to others, or incapable of managing himself or herself and his or her affairs." The number of

flaws that have been found in this definition, and the ingenuity that has been expended in extricating habitual drunkards from its meshes, are surprising. The most ingenious of these objections lies in the strict meaning attached to the word "habitual." It has been gravely held that even if a man is an habitual drunkard, and commits an offence while drunk, the magistrate cannot sentence him because the offence may be the consequence, not of his habit of drinking, but of the particular act of drunkenness that he had indulged in at the time! It has also been said that an habitually drunken prostitute cannot be brought within the definition since her drunkenness rather assists than hinders her in the management of her "affairs"! Happily, these particular monstrosities of legal wisdom will be abolished if the definition recommended by the Committee is accepted. The definition runs:-"An inebriate is a person who habitually takes or uses any intoxicating thing or things, and while under the influence of such thing or things, or in consequence of the effects thereof is (a) dangerous to himself or others, or (b) a cause of harm or serious annoyance to his family or others, or (c) incapable of managing himself or his affairs, or of ordinary proper conduct." This definition includes as inebriates not only habitual drunkards, but habitual drug-takers, and is so far a great advance on the previous one. It avoids the first of the defects that we have recited, but in other directions we think it opens the door too wide. "Serious annoyance" is a vague term unknown to the law, and will scarcely pass the scrutiny of the Government draughtsman; while "ordinary proper conduct" is equally vague, and is already covered by the expression "managing himself and his affairs," if this last is properly understood and interpreted. The provision of "guardianship" is a novelty in legislation, and seems well adapted to meet the case of inebriates who cannot be persuaded toadopt the more serious course of placing themselves in a retreat. The guardian is to be empowered (a) to prescribe a place of residence for the inebriate; (b) to deprive the inebriate of intoxicants, and prevent him from obtaining them; (c) to require the inebriate to submit to the control of nurses or attendants; (d) to warn sellers of drink and drugs not to supply the inebriate: supply after warning to be an offence against the Act. Guardianship may be voluntarily submitted to or compulsorily imposed, the provisions in the latter case being slightly more stringent than in the former. The Committeeendorse the opinion of two previous Committees. on the subject, that "great and widespread. distress" is caused by inebriates who do not commit offences and therefore cannot be dealt with compulsorily under the present law. The Committee are convinced that power to deal with such inebriates is urgently needed; they have failed to find satisfactory reasons against the constitution of such powers, and they point out very justly, that the alternative to interfering

with the liberty of the inebriate is permitting the inebriate to interfere with the liberty of other people. It is now thirty-six years since provisions of this character were first recommended as urgent. We trust that no sentimental and misplaced tenderness for the liberty of the drunken subject will be allowed to stand in the way of his being prevented from interfering with the liberty of his sober fellows. Much consideration is given to the question of finance. The Committee says in plain terms that the expenditure of the Lancashire, Yorkshire, and London County Councils upon Inebriate Reformatories is unjustifiable and a waste of public money, and that "the mere fact that a person has become an inebriate should not of itself entitle him to be maintained under conditions altogether superior to those to which he has been accustomed." The cost of provision ought not, in the opinion of the Committee, to exceed £150 per bed, nor ought the maintenance rate to exceed 11s. 4d. per week. It is time, indeed, that an authoritative voice was raised against the profligate expenditure of public money by Local Authorities. It is on the score of economy, largely, that the Committee recommends the transfer of Reformatories to the State. but it gives with great cogency many other reasons.

#### DEATH CERTIFICATION BY MIDWIVES.

THE Departmental Committee of the Home Office, lately appointed to inquire into the question of Coroners' powers, might well ponder a case which occurred at Lincoln last week, and consider whether it and similar occurrences do not come within its reference. In the instance under notice a child was certified by a midwife and declared by a nurse, neither of whom was present at the birth, to be still-born, and in due course burial took place. Suspicion being aroused, an exhumation order was obtained from the Home Office, and medical examination showed that the child had breathed, though it was impossible to say that it had had a complete separate existence; and, moreover, that the child had failed to live through neglect at, or immediately after, birth. The Coroner, Mr. Trotter, remarked—as well he might—on the defects in the law with regard to the burial of still-born children, and expressed astonishment that, when infantile mortality is so much spoken of and deplored, those in power take no steps to amend the present faulty state of things. He proceeded to say that he could not conceive of anything easier than for people who wished to hush up the circumstances of the birth of a child who died shortly after being born, than to have the child buried on information of the sort which was given in this case, no qualified or responsible person being called in to advise as to whether the child had been born alive or not. These very proper remarks emphasise, as unfortunately those of too few coroners do emphasise, a scandal of enormous magnitude. Every medical man knows the fatal facility with which a newly-born child may be done to death and buried as still-born. All that is necessary is that no medical man shall be about the place to testify to seeing the child alive. Now, though the

doctor should be anything but a common informer, he is, by the exigencies of his position, the protector of the newly-born infant against the machinations of interested parties, be they parents or neighbours: and it is the natural result of a law which encourages the poor to do without medical assistance at their confinements, that those vicious parents who wish to murder their offspring should seek to find venal accomplices in the class to which they belong. That still-births should be unrecognised by the burial laws is equally scandalous. No child asserted to be still-born should be buried with out a medical certificate, and, if no doctor was present at the birth, a post-mortem examination of the body should be made as a matter of course. Another unsatisfactory feature is the frequent absence, as in the Lincoln case, of any attempt to encourage life, by artificial respiration or otherwise, in a newly-born child who may be an unwelcome intruder into the family. A medical man attending a confinement feels it his duty as much to resuscitate an apparently-dead child as to preserve the mother's own life; but with the abrogation or supersession of the medical attendant, the duty of doing the utmost for such an infant speedily fails to be recognised. In the particular case of which we are speaking, the Coroner, at the jury's suggestion, censured the two women, telling them they would be "lucky" if they escaped punishment for what they had done, and the Chief Constable has since taken proceedings against both. Such proceedings, however, after all, are only technical, and the fringe of the question only is touched. The parents who connive at the suffocation of the new-born, or neglect to provide proper facilities for their preservation at birth, are the parties whom a well-framed law would gather into its meshes. Such parents, for instance, as those who allow a child to be born when the mother is seated at stool or on the chamber, and make no effort to save the infant's life. However poor and ignorant people are, they know that infants born under such circumstances will not survive unless released and placed in warm and favourable surroundings, and it is prima facie evidence of infanticide for a child to be allowed to perish under such conditions. Had the Children's Act of last session devoted itself less to juvenile smoking and more to crimes of this nature, its usefulness might have been even greater than

#### CURRENT TOPICS.

An Alpine Tragedy.

On January 13th yet another name was added to the long list of Englishmen whose lives have been lost in the fascinating but fatal pastime of Alpine climbing. In this instance we regret to say that the victim was a young medical man who had already achieved a considerable amount of distinction on the threshold of his career. Mr. J. Evan Spicer set out with his brother Gerald from Lenzerheide in a westerly direction, and they were overtaken by a violent snowstorm which drove them down the steep Domleschg slope. As they did not return, a search party went out and found Gerald in a terribly exhausted condition. He reported that his brother had been swept away by an avalanche,

and was lying at the bottom of a gorge. Lenzerheide is a small health resort about eleven miles from Corbe, on the road to St. Moritz. Mr. H. Evan Spicer was educated at Clifton and at Trinity College, Cambridge. He was M.A., M.B., and B.Sc. of Cambridge (1903), and was medically educated at the London Hospital, where he held various posts, including that of Medical Registrar. The son of Mr. Evan Spicer, formerly chairman, and now Alderman of the London County Council, he carried on the family traditions by identifying himself with Free Church philanthropic work. At the time of his death he was only thirty-three years of age. His premature death once again raises the question whether the game of this dangerous mountaineering, so to speak, is worth the candle. What recompense is there for this unceasing toll of the flower of our manhood?

#### The Dangers of Pasteurisation.

In our "Weekly Summary," recently (December 30th, 1908), we briefly referred to an important investigation into the bactericidal properties of milk made by Evans and Cope, of Philadelphia. As the points raised are of considerable practical importance, we return to them here. Briefly, Evans and Cope showed that even moderate heating of milk destroys or impairs the bactericidal properties which raw milk possesses in a considerable degree. If pasteurised or sterilised milk, therefore, should become contaminated, it furnishes a much better medium for the growth of organisms than ordinary untreated milk. At the present time, many milkpurveyors have learnt that "pasteurisation" is a word to conjure with, and they inform the public that they sell nothing but pasteurised milk. If we had any assurance that the milk was efficiently protected from contamination after undergoing the pasteurising process, it would be all right. But in many cases the milk is exposed to obvious sources of contamination, such as street dust, dirty hands, or dirty vessels. The net result, under such circumstances, is that, while the pasteurisation may give protection against tuberculosis, it considerably increases the consumer's exposure to various staphylococal and bacillary infections, including such diseases as scarlatina, diphtheria, and typhoid fever.

#### Fleas and Plague in the Old Testament.

SIR HAVELOCK CHARLES contributed recently to a contemporary an ingenious speculation concerning an incident recorded in the Book of Samuel, which has given rise to much discussion on the part of commentators. It will be remembered that when, in the warfare between the Israelites and the Philistines, the ark of God fell into the hands of the latter, it was followed in its travels by "a very great destruction," the men of the cities of the Philistines where the ark rested being smitten with "emerods in their secret parts." Eventually the ark was restored to Israel, only to cause a worse destruction, fifty thousand and three score and ten among those who pried into it being smitten. It is recorded also that mice marred the land of the Philistines at that period, and they must have been supposed by the Philistines to have some relation to the prevailing epidemic, since images, not only of emerods, but of mice, were made to allay the anger of God. Sir Havelock Charles suggests that in the story we have an account of an epidemic of plague. The ark, he says, during its stay in the temple of Dagon, infested, like all Eastern temples, with rats, became infected by plague-laden fleas, to which its covering of badger-skins gave safe harbour. During its subsequent travels, even till it came to the prying Israelites of Beth-shemesh, it distributed plague. When the ark became safe from further inquisitive meddling, its power of propagating disease disappeared. The suggestion is an interesting and ingenious one, though we are scarcely surprised that the high Church dignitary, to whom Sir Havelock Charles first made it, did not receive it as it was meant.

#### A Medical Hero.

THE medical profession has its heroes, although it has not yet its "V.C." We are glad to remind our readers of the brave act of one of our Austrian brethren. The feat may, perhaps, best be narrated in the terse words of the special correspondent of the Pall Mall Gasette, whose telegram from Vienna was published in that journal on January 7th, as follows: - "By the death of Dr. Alfred Kuehne, Vienna has lost a great medical hero. Some winters ago, during a heavy snowstorm, a southern railway express ran into a sleigh at a grade crossing. The locomotive was brought to a standstill after running over the sleigh driver and crushing both his legs. Unconscious from the shock and loss of blood, the man lay under the engine, and it was impossible to extricate him. Dr. Kuehne crawled under the locomotive, and by the flickering light of torches amputated both legs, bound up the great arteries, and sewed together the wounds. To do this he lay three hours on his stomach in the snow, with the heated engine im-mediately over him. When at last the mutilated man was released from his position he was taken to the general hospital. The famous Professor Billroth declared Kuehne's work was a great deed of heroism and surgery, and his name would never be forgotten in the annals of Austrian medicine."

#### Noblesse Oblige and Medical Fees.

In the City of London Court, recently, a medical man brought a successful action against the holder of a Portuguese title. The circumstances of the case illustrate in a remarkable way the attitude of many persons with regard to the discharge of liabilities contracted through engaging the services of medical practitioners. A claim for the modest sum of £23 7s. was made against the "Baron" for attendance upon himself and a lady. It was shown in evidence that the defendant held six hundred shares in an Argentine company, and had an actual bank balance of £363. Judge Lumley Smith expressed an opinion that it would be better for the plaintiff to accept £5 per month—on what grounds it is exceedingly difficult to imagine. Why should the Court go out of its way to shield a man whose means had been shown to be ample, and whose own personal defence appears to have been conspicuous by its absence? The plaintiff very properly insisted upon the whole amount being paid. The learned judge pointed out that the sum being over £20, he was master of the situation, and the defendant "must make terms with the enemy." The last elegant phrase appears to be consistent with the familiar attitude of clients and courts when medical men pluck up courage enough to demand payment of their just dues. In the end the "Baron" was ordered to pay the whole sum, with costs, and an intimation was made that his bank balance was liable to attachment.

#### The Scotch Oath.

A FAIRLY wide-spread movement seems to be taking place to replace the time-honoured absurdity of kissing the book by the Scotch form of oath, by which the witness merely raises his hand and swears to tell the truth, the whole truth, and nothing but the truth. Several High Court judges have started the new term by a determined effort to make witnesses swear in this fashion, and magistrates and coroners are following suit. It is but the other day that witnesses were snubbed and brow-beaten by judicial authorities when they wished to follow this procedure, and we may take comfort in the fact that it is to the efforts and example of medical men that the happy change is due. The habit of kissing the book, however picturesque a survival of the Middle Ages, is about as barbarous a practice as most of the methods current in those piping times, and when but one book was provided for each court, and used month after month by countless swarms of witnesses of every shade of society, the opportunities for infection were manifold. Many cleanly-minded people kissed their own thumb instead of the book -a practice severely condemned in a medical man by Judge Bacon only last week-and the wise ones only made a pretence of inosculating the dusty tome at all; if, however, the Scotch oath is adopted universally these subterfuges will no longer be necessary. We congratulate those legal dignitaries who are sufficiently awake to the requirements of modern hygiene to endeavour to persuade people to adopt the impressive and dignified form of oath used in Scotland, and we hope the stupid and dirty old custom will soon be left to rust with broad-swords. thumb-screws, and powdered wigs, in the mouldy caverns of oblivion.

On Thursday, the 21st instant, the Conjoint Scotch and Irish Committees will hold a meeting at 4 p.m., at the Hotel Cecil to discuss the monopoly at present bestowed upon the London colleges in most of the larger hospital appointments in London and in many larger hospital appointments in London and in many of the provincial institutions. In the evening a dinner will be held at the Hotel Cecil, when several prominent representatives of the Scotch and Irish colleges will be present. Tickets (7s. 6d. each, without wine) can be obtained of the hon. secs., Dr. Hobbs-Crampton, Myddelton Square, E.C., or Dr. Parsons, 126, Fulham Road, S.W.

#### PERSONAL.

Mr. G. N. Biggs, F.R.C.S., has been appointed Aural Surgeon to the Evelina Hospital for Sick Children.

An International Hygienic Exhibition is being organised at Rio de Janeiro this year in connection with the Latin American Congress in that city. The Exhibition will be open from August 1st until September 30th.

THE LORD PRESIDENT OF THE COUNCIL has appointed Francis E. Fremantle, Esq., M.B., F.R.C.S., M.R.C.P., Medical Officer of Health for the County of Hertford, to be a member of the Committee appointed to consider the working of the Midwives

DR. CHARLES BURLAND, M.D., F.R.G.S., Board of Trade Medical Inspector for the Western District of Scotland, has been transferred to the Liverpool district, where he will be associated with Dr. J. R. Stocker.

THE Surrey County Council has appointed Mr. Fdward Hinks, Public Analyst for the County, in succession to the late Sir Thomas Stevenson, M.D., to whom he was senior assistant for seven years.

WE understand that Surgeon-General Bomford, C.I.E., M.D., Director-General of the Indian Medical Service, intends retiring before the expiration of his term of office next December. Surgeon-General Bomford has just been created a Knight Commander of the Ladies Empire. of the Indian Empire.

DR. EDWIN RAYNER, senior member of the honorary medical staff of the Stockport Infirmary, has resigned that position in consequence of the pressure of other duties. Dr. Rayner has been connected with the honorary medical staff of the Infirmary since 1875, and the Board, to mark a warm appreciation of his services, have appointed him Consulting Surgeon to the Infirmary and a Vice-President.

SEVERAL English women doctors are doing good work among the victims of the great earthquake. In Rome itself Dr. Ruth Bensusan is superintending the work of procuring supplies for the wounded refugees. She is a member of the English Relief Committee. Dr. Taylor, with whom is an English nurse, is working hard in Calabria. Dr. Caroline Matthews has left the Tiber in a ship specially chartered by the English Committee to carry food, clothes, and medical necessities to Calabria.

On the Legion of Honour list for January 1st is the name of Louis Bazy, a House Surgeon in the Paris name or Louis Bazy, a House Surgeon in the Paris hospitals. The decoration has been conferred on him by the President of the Republic personally for gallantry in the operating-room. He was assisting in an operation on a patient suffering from empyema, when a drop of pus splashed and entered his eye. He said nothing, and continued his duties until the operation was successfully concluded. Only then did he have his eye treated, but it was too late, and violent infection set in. Acute inflammation followed, lasting six months, and causing great pain. At length the eye had to be removed.

MR. JOHN CHARLES LANE, of Moseley, Worcestershire, solicitor, bequeathed £100 each to the Birmingham General Hospital, the Queen's Hospital, Birmingham, the Birmingham Blind Asylum, the Birmingham Deaf and Dumb Institute, the Birmingham Ear and Throat Hospital, the Birmingham Eye Hospital, the Birmingham Children's Hospital, the Jaffray Hospital, the Birmingham Skin and Lock Hospital, the Middlemore Homes, and the Moseley Park Hospital. After family bequests have been satisfied, the ultimate residue of his property, which has been valued at £31,280, is to be divided equally between the above charitable institutions, which will apparently share between them a further £12,000.

A PROVINCIAL sessional meeting of the Royal Sanitary Institute will be held in Manchester on Friday, Institute will be held in Manchester on Friday, January 22nd, including, at 2.30 p.m., a visit to the new Manchester Royal Infirmary, and at 7 p.m. a discussion in the Municipal School of Technology on the Manchester Royal Infirmary from the Hygienic, Sanitary, and Æsthetic Points of View, which will be opened by Mr. Edwin T. Hall, Vice-President R.I.B.A., followed by Mr. John Brooke, F.R.I.B.A. (architects of the infirmary). The chair will be taken by Mr. H. D. Searles Wood, F.R.I.B.A.

### A CLINICAL LECTURE

ON

#### CEREBRAL ABSCESS.

By WILLIAM TAYLOR, M.B. Dub. Univ., F.R.C.S.I.,

Surgeon to the Meath Hospital and Co. Dublin Infirmary, &c.

HAVING recently had some cases of intracranial complications of old standing suppurative disease of the middle ear under my care in the hospital, and having accidentally come across this patient, on whom I operated in 1903, I thought it would not be inappropriate for us to consider the subject of cerebral abscess this morning. Let me now briefly read to you the notes of this case, and remind you of the case we had in the adjoining ward some three weeks ago, and then we shall be in a position to review the subject generally.

J. R., æt. 17, was admitted under my care into the Meath Hospital on August 3rd, 1903, from Cork Street Fever Hospital, into which institution he was taken two days before on account of severe headache and vomiting. He had had a discharge from both ears for a number of years, and had attended as an out-patient at one of the eye and ear hospitals for some time. A few days before admission into Cork Street Fever Hospital he began to complain of severe headache, which was chiefly confined to the left side. He vomited almost continuously for two days, especially if he moved his head from one side to the other. The evening before going into hospital he had a shivering fit. On admission into Cork Street Hospital his temperature was found to be 104°, and the pulse varied from 90 to 100. He looked very ill, and complained much of the intensity of the pain in his head.

Dr. T. L. Sandes, who was doing temporary duty as Assistant Medical Officer, examined the patient, with the following result: There seemed to be no discharge from the left ear, but it was full of granulation tissue; there was a profuse discharge from the right ear. Tenderness was not complained of on percussion or firm pressure over either side of the head. The fundus of the eye was examined on each side. The fundus showed early evidences of "choked disc." but the right fundus was normal. The boy spoke distinctly enough, but, it was thought, somewhat slowly, as if his cerebration was dull. There was no evidence of paralysis or paresis of any cranial nerve, or of any of the limbs. He was deaf, but stated that he had been a little deaf for a long time.

Dr. Sandes considered the case one of cerebral abscess, and accordingly communicated with me. I saw the patient about 11.30 p.m., and found his condition much the same as already detailed, with this exception—that he no longer complained of the headache, but he seemed more or less delirious, and spoke rather incoherently, and pronounced some of his words indistinctly. The left pupil was more dilated than the right, and contracted very sluggishly to light. The temperature was still about 104°, and the pulse about 90. Considering the severity of the headache, and the persistent high temperature and acuteness of the case, I was more disposed to look upon the case as one of septic meningitis, but determined to operate upon the patient next morning as soon as he could be removed to the Meath Hospital, where the facilities for performing an operation such as would be required were much better. Next morning he was in a semi-unconscious state. Temperature was still high; pulse had fallen to 80. The left pupil was widely dilated and did not react to light; the right pupil was only moderately dilated.

He was immediately trephined over the left temporosphenoidal region. This site was selected: first, because at that time it was considered to be the commonest situation of intracranial abscess of otitic origin; secondly, on account of the indistinct pronunciation of some of his words; and, lastly, on account of the dilatation of the left pupil. These

points, however, I will draw your attention to later on. A disc of bone was removed directly above the external auditory meatus, and the opening quickly enlarged in every direction, until it measured roughly a inches antero-posteriorly, and 11 inches vertically. The dura mater bulged into the wound; it was very tense, and did not pulsate. A flap of dura was then reflected upwards, when the brain protruded well beyond the opening into the skull. On palpating the protruding brain to see whether I could detect a softened spot, my finger actually opened into the abscess cavity, so superficial was the abscess and so ready was it to rupture. I assume it was only prevented from rupturing into the membranes by the force with which the increased intracerebral pressure applied the surface of the temporo-sphenoidal lobe to the surrounding membranes. The finger was passed into the abscess cavity to explore it. The cavity was very gently and cautiously syringed with saline solution, and some sloughing brain tissue removed. Two drainage tubes were introduced side by side into the abscess cavity, and brought out through an opening in the centre of the dural flap, which was adjusted with catgut sutures, as well as the protruding brain admitted, to the cut margins around the bone opening. The scalp was then brought up, and a hole cut near its: base for the drainage tubes to pass through. The edges of the flap were adjusted by silkworm gut sutures, and the tubes fastened to the edges of the opening in the scalp by similar sutures. The tubes were cut so that they protruded merely 1 of an inch beyond the scalp. The usual dressings were applied, and the patient returned to bed. It was noticed that directly the abscess was evacuated the pulse increased in rapidity to 140 to the minute.

The subsequent course of the case was uneventful. Morphine had to be given rather freely for 24 hours after operation on account of the irritability of the patient. His temperature became normal in a couple of days, and his pulse gradually quieted down to the normal. Six weeks subsequently a radical mastoid operation was performed, and he has since then remained perfectly well. His hearing is much better, and beyond the fact that you can feel the defect in the skull from which the bone has been removed, there is no evidence to suggest that he had ever had any intracranial complication from his suppurative

ctitis media.

A few weeks ago you may remember we had another somewhat similar case, which was sent here from Cork Street Fever Hospital. The history was different in a few respects, viz., his otitis media dated back to the age of 7 years—he was then about 30 years of age—the otitis was double, too, and discharged freely for a number of years. It then dried up and remained well for some 14 years, when it returned without cause, so far as the patient knew. He was admitted into Cork Street Fever Hospital for enteric fever, and it was during convalescence his troubles began. For a couple of days he had very severe vomiting, distinctly cerebral in character—that is, it was apparently purposeless and unaccompanied by nausea, it was independent of food, and seemed to be produced by any sudden movement of the head or change of position of the head from one side to the other. He complained of headache; for a short time one day he had loss of memory—he could not remember where he lived, or where he was, or for what reason he came into hospital, nor even his name; this lapse of memory was only temporary. His temperature was sub-normal, and his pulse varied from 70 to 84 in the minute.

sionless, or it may assume, as Macewen puts it, "a meaningless smile with which the features are not lit—

it is too mechanical."

Choked disc may be present; it usually is, and is generally most marked on the affected side. The patient med to answer rather slowly. There was no tenderes on pressure nor pain complained of anywhere on percussion over the skull. He quickly became conscious, but from the clear history of loss of mory, severe cerebral vomiting and headache, which re sent with the patient from Cork Street Fever Hosal, I trephined over the left temporo-sphenoidal are and evacuated a very large abscess. That situate and was again selected for the following reasons: the terminal stage is characterised by the evidences of the abscess either into the ventricles or on to the surface into the membranes, or by the evidences of spreading cedema. Rupture is recognised by a convulsion, profound coma with widely dilated pupils, livid face, and hurried or stertorous respirations. The pulse runs up from 40 or 60 to 120. 140.

by a convulsion, profound coma with widely dilated pupils, livid face, and hurried or stertorous respirations. The pulse runs up from 40 or 60 to 120, 140, or 160. The temperature bounds up from normal or sub-normal to 104°, 105°, or more, and death takes place within a few minutes to a few hours. Spreading cedema is indicated by gradual onset of coma, dilatation of the pupils, quickening of the pulse, with loss of its tension, while the breathing not infrequently assumes the Cheyne-Stokes type, and the temperature rises; finally, death takes place from respiratory paralysis.

Unfortunately, one does not generally see cases of cerebral abscesses so typically illustrating the phenomena of the three stages just described. The patient is generally found in the second stage, and, as a rule, well on in it, and bordering upon the third or terminal stage.

Ballance classifies the symptoms of brain abscess as follows:—

(1) Those due to the presence of deep-seated pus independent of its locality, such as the febrile state, with perhaps a rigor and vomiting.

(2) Those due to increase of tension within the skull,

(2) Those due to increase of tension within the skull, such as purposeless vomiting, slow, high-tension pulse, choked disc, and torpor.

(3) Those due to irritation or suppression of function of particular parts of the central nervous system, such as epilepsy, anæsthesia, paralysis, perversion or loss of one or other of the special senses.

The phenomena of Ballance's third group are, of

The phenomena of Ballance's third group are, of course, the localising phenomena indicating the area of brain in which the abscess is situated, phenomena which might just as well be produced by a tumour.

As regards the site of brain abscesses, traumatic abscesses will be found directly underneath the situation of the injury. Those from the frontal sinuses, for example, will be found most frequently in the frontal lobes, while those taking their origin from infective otitis media will be found either in the temporo-sphenoidal lobe or in the cerebellum. It has generally been stated that the commonest site for abscess secondary to suppurative otitis media is the temporo-sphenoidal lobe, but I am inclined to doubt the correctness of the statement. Certainly, in children, at all events, I have seen cerebellar abscess more frequently, and the statistics of St. Thomas's and the Great Ormond Street Hospitals, quoted by Mr. Ballance in his book on "Some Points in the Surgery of the Brain," go to show that abscess of aural origin is more frequent in the cerebellum than in the temporo-sphenoidal lobe.

As regards the localising evidences of an abscess in the temporo-sphenoidal lobe, I may tell you at once that there may be none whatever, and this is more especially the case with abscesses situated in the right temporo-sphenoidal lobe, which is the most "silent" area of the brain.

We may have the cortical centre for hearing partly or entirely involved, producing tinnitus, hyperacusia, or absolute deafness of the opposite healthy ear. Provided the other ear is known to be healthy, this may be of importance.

be of importance.

The cortical centres for taste and smell, which are situated in the lower and anterior extremity of the temporal lobe, forming the uncinate gyrus, may be effected.

Sensory aphasia often occurs in abscess of the left temporo-sphenoidal lobe; the auditory word centre and visual word centre are those chiefly involved.

A large abscess in the temporo-sphenoidal lobe may cause paralysis of the opposite side of the body, which

There was neither paresis nor paralysis. The fundi of both eyes were normal, although examined twice at antervals of some days. He spoke clearly and distinctly, but again, when I saw him, I thought he pronounced some words indistinctly, and I thought he seemed to answer rather slowly. There was no tenderseemed to answer rather slowly. There was no tenderness on pressure nor pain complained of anywhere on firm percussion over the skull. He quickly became unconscious, but from the clear history of loss of memory, severe cerebral vomiting and headache, which were sent with the patient from Cork Street Fever Hospital, I trephined over the left temporo-sphenoidal lobe and evacuated a very large abscess. That situation was again selected for the following reasons: first, there was some indistinctness in the way the patient pronounced some words; secondly, there was a clear history of loss of memory for words, showing some involvement affecting the speech mechanism. The pulse became greatly accelerated directly the abscess was evacuated, but, unfortunately, the patient never recovered consciousness. His temperature rose quickly and steadily to 105.4°; his pulse kept fast; the pupils remained widely dilated; and he died comatose some 24 hours after the abscess was opened. The post-mortem showed the temporo-sphenoidal lobe on the left side to have been extensively destroyed by a large abscess which still contained a small amount of pus, though the drainage tube was well within the abscess cavity. The most noticeable feature in the case was the absence of any sign of choked disc in the presence of so large an abscess. As regards the ætiology of cerebral abscesses, the

As regards the etiology of cerebral abscesses, the commonest causes are chronic suppurative disease of the middle ear and trauma; then comes pyæmia, following septic processes in the lungs, such as gangrene, abscess in the lung, chronic empyema, etc.

The most important group comprises those which occur as the result of a more or less direct extension of septic processes from suppurative disease of the middle ear, mastoid cells, and the sphenoidal and frontal sinuses. It is thus obvious that infection may reach the brain either by direct inoculation; by metastasis through the blood stream (pyæmia); by direct extension of the suppurative process from extracranial cavities; and by inoculation through infected blood-vessels (emissory and diploic veins) which connect with the extracranial or extradural suppuration.

Symptoms and Signs.—It is customary in this country to follow Macewen in describing the clinical course of a cerebral abscess. He describes three distinct stages:—(1) The initiatory or irritative stage. (2) The stage of fully-formed abscess, sometimes termed by him the latent stage. (3) The terminal stage.

The features characteristic of the first stage are: Severe headache, referred chiefly to the ear and temporal region of the affected side, but radiating in different directions; a rigor, which varies from a mere feeling of chilliness to a rigor so severe that it may be mistaken by the uninitiated for a convulsion; vomiting, cerebral in type; a rise in temperature, and quickness of the pulse. There is, in addition, generally the history of the antecedent condition—usually a history of long-standing discharge from the ear, with possibly the statement that the discharge ceased directly before these severe symptoms began. This stage lasts a variable time, from ten or twelve hours to two or three days.

Second stage: Latent stage, or that of fully-formed abscess, is characterised by a fall in the temperature to normal or sub-normal; a slow pulse—70, 60, or even 40 to the minute; dulling of the intellect; slow cerebration—he answers questions slowly and distinctly, but he seems to require a much longer time to understand the question put to him, as well as to formulate the reply; sometimes you are almost about to repeat the question, thinking he did not hear it, when out comes the answer, uttered slowly and generally correctly. The vomiting of the first stage generally ceases, and the headache subsides, or, at all events, it is no longer complained of. There is no actual paralysis unless the abscess is situated about the motor areas, but there seems an inability to apply the strength, and the patient seems incapable of any sustained mental effort. Constipation is obstinate, and there may be retention of urine. The face is expres-

may be of cortical or capsular type. The paralysis due to pressure of the abscess upon the motor fibres as they are closely grouped together while passing through the internal capsule is that of a complete contralateral hemiplegia, developing quickly in the order: leg, arm, face; and it is generally associated, as might be expected, with hemianæsthesia. The paralysis arising from pressure of the increasing abscess upon the motor fibres as they pass down from the different motor areas of the cortex, is a slow, progressive paralysis, gradually extending from the face to the arm, and lastly the leg, but generally without anæsthesia.

The third nerve on the same side may be paralysed in the case of temporo-sphenoidal abscess. Ballance lays great stress on this fact. The paralysis is rarely lays great stress on this fact. The pararysis is factly complete, but, he says, "a stable pupil on the side of the suspected abscess clinches the diagnosis."

Lastly, there may be paralysis of the "naming entre"—that is, there may be a lesion or pressure upon that centre which presides over the nervous mechanism by which the ideas of objects are correlated with their This centre seems to be located in the left temporo-sphenoidal lobe. It was probably this centre which was affected in the last case you saw here, where which was alected in the last case you saw here, where the patient could not remember where he lived nor even his own name for a while. The condition may be termed "aphemia." A considerable area of even the left temporo-sphenoidal lobe seems to be "silent"; thus a small abscess may exist there without producing any localising phenomena. It is then simply by obtaining the clinical history of a discharge from the ear, and excluding cerebellar abscess, the localising evidences of which I will now mention, that you will be enabled to treat the case satisfactorily.

An abscess in the cerebellum, while small, may give rise to few symptoms, and the patient may be able to go about; but, as it increases in size, serious symptoms develop.

Vertigo is marked, and he is unable to co-ordinate his movements. He reels from side to side if he attempts to walk; even when sitting up in bed the patient cannot be got to sit quite upright; he tends to fall, as a rule, towards the side opposite to that in which the abscess is situated. There is frequent yawning of a mechanical character, and the head is retracted. The vomiting of the first stage may persist,

especially on movement.

The respiration is greatly embarrassed, may be of the Cheyne-Stokes type, and may suddenly become arrested, due to direct pressure upon the respiratory centre. This sudden arrest of respiration has not in-frequently taken place while the anæsthetic was being administered for the purpose of opening the abscess. Should such an accident occur, artificial respiration should be maintained, the skull quickly opened, and the abscess evacuated. The removal of the pressure from the respiratory centre by the evacuation of the abscess allows it to resume its function again. Several cases of this nature, in which patients' lives have been saved, are on record. In cerebellar abscess, paresis of the external rectus muscle on the same side is one of the commonest isolated signs of cranial nerve ir volvement

Skew deviation of the eyes is a not uncommon sign, one eye being turned upwards and outwards or up-wards and inwards, the other being turned downwards and outwards

Nystagmus may also be detected.

A cerebellar abscess may cause a paresis of the limbs on the same side as the lesion; the face is not involved, and the paresis is not accompanied by rigidity; the muscles are flaccid. The lesion tends to involve the larger movements rather than the finer, and is not associated with ankle-clonus.

The knee-jerk on the side of the lesion is often exaggerated, but it may equally be diminished. It is not my intention to go into the question of localisation of cerebral abscesses in other situations. The traumatic is easily localised by the injury, and the temporosphenoidal and cerebellar abscesses are the only other abscesses frequently met with. In any case, it is a question of knowing the functions of different areas of the brain. Tenderness on percussion over the site of the abscess should always be sought for. It should be remembered that these abscesses of otitic origin are

not infrequently complicated with septic thrombosis of the sigmoid or lateral sinus, and, if so, you will invariably find that the sigmoid sinus thrombosis phenomena predominate over the cerebral, and thus mask them. The general cerebral phenomena only assert themselves when the septic sinus condition has been relieved by operation.

General Diagnosis. - Abscess of the brain must be dis-Cervical Diagnosis.—Abscess of the brain must be distinguished from inflammation of the membranes. Cervical rigidity and Kernig's sign are more suggestive of meningitis than abscess, while a lumbar puncture will show whether the cerebro-spinal fluid contains an increased number of leucocytes, a condition always present in meningitis and absent in cerebral abscess,

unless it is complicated with meningitis.

Sigmoid or lateral sinus thrombosis is characterised by the peculiarly spiky course of the temperature. The condition of the pulse is that of severe systemic sensis. It is quick-110 to 140-and small. There are multiple rigors. There is tenderness over the mastoid, and perhaps along the internal jugular vein, and there may be cedema over the mastoid process and pulmonary phenomena.

Tumour of the brain is hardly likely to lead to diffi-ilty in diagnosis from abscess. The antecedent culty in diagnosis from abscess. history is the important thing.

Sometimes in otitis media one finds symptoms produced by a reflex disturbance through the trigeminal nerve, which may closely resemble intracranial extension of the disease. There is no rise of temperature, but great tenderness, headache, nausea, and even vomiting may occur. The tenderness is, however, superficial, and conforms with the sensory distribution of the trigeminal nerve. Even the hair cannot be touched without producing discomfort. Cushing states that he has seen several cases of that sort recover without operation, and he attributes the phenomena to a mild degree of dural involvement. Cushing also states that another still more common complication due to an acute serous meningitis (not of bacterial origin, at all events, so far as is known) may closely simulate abscess. In such cases a lumbar puncture or a decompressive craniectomy, with evacuation of the fluid, is sufficient to cure. He therefore advises that in any exploratory operation for abscess, if a super-abundance of clear fluid is disclosed, it is not wise to be too persistent in the search for pus.

Prognosis.—Without operation the prognosis is hopelessly bad, and, even after operation in the most experienced hands, the mortality must be at least 50 per cent. The treatment consists in the evacuation of the abscess the moment the diagnosis is made. Delay of a few hours may mean the rupture of the abscess or the development of a spreading cedema which will terminate fatally, in spite of the evacuation of the abscess, as witness the case operated upon recently.

There are two methods of procedure. Otologists-recommend starting with the cause of the trouble. They open the mastoid antrum, throw this cavity and the attic of the ear into one, and then follow wherever the disease leads, upwards into the middle fossa and temporo-sphenoidal lobe, or backwards, removing the mastoid cells and exposing the sigmoid sinus, and thus explore the cerebellum. For this method of procedure there is much to be said. Still, in these days of specialism, general surgeons have not much opportunity of becoming familiar with the performance of radical mastoid operations, and they will probably obtain better results if they attack the brain trouble directly, and leave the ear trouble to be dealt with later on Macewen, at all events, favours the latter method, and so, indeed, does Cushing. Ballance, however, favours the mastoid route, but then Ballance made that operation more or less of a speciality. I have done both, and in any case in which the symptoms are at all urgent I prefer to go direct for the brain.

To explore the temporo-sphenoidal lobe, the simplest and most efficient method is that of exploration by the muscle-splitting temporal route of Harvey-Cushing. It can be done in a few minutes; the squamous portion of the temporal bone is thin and easily cut through. One can thus explore intracranially the roof of the tympanum, the dura over it, and, if necessary, the temporo-sphenoidal lobe, and in case an abscess is found therein, it can be most efficiently drained at its most dependent part. After exposing the brain, it can be explored by a hollow needle with a blunt end and one or more side openings, or by a long, narrow-bladed metacarpal knife. Not infrequently in cases of chronic cerebral abscesses the wall becomes so thick and firm that nothing but a sharp knife will penetrate it. I have seen such a wall to a chronic cerebral abscess. When pus is found the abscess should be freely incised here, as elsewhere, and in cutting you should avoid the sulci as far as possible, so as to avoid the risk of hæmorrhage. Provide for free drainage. Some men always irrigate the cavity, but it should be done with the utmost caution and gentleness, due precaution being taken to prevent any increased tension within the cavity, or any diffusion of the septic process to the surrounding areas. Drainage is difficult on account of the fact that the cerebral substance about the edges of the incision in the brain become edematous, and tends to occlude the opening, and thus cause retention of the discharges. I generally use two drainage tubes, each about \(\frac{1}{2}\) in in diameter, placed side by side. These are brought out through an opening in the centre of the dural flap, and project about \(\frac{1}{16}\) to \(\frac{1}{2}\) of an inch beyond the edge of the scalp, to which they are fastened by a couple of silkwormgut sutures. Dressings are then applied, and the patient put into bed with the affected side of the head down, so as to facilitate drainage.

A cerebellar abscess, if urgent, can quickly be explored as follows: Place the trephine so that its anterior border is just behind the posterior border of the mastoid process and its upper border just below Reid's base line. After opening the dura, pass the exploring needle or knife in a direction forwards, upwards, and inwards, through the cerebellum towards the posterior surface of the petrous portion of the temporal bone. It should be remembered that if the abscess is situated towards the anterior and inner aspect of the cerebellar hemisphere, the needle or knife must be passed inwards, forwards, and upwards for as much as 2 inches from the surface before pus will

be found.

Having once opened a cerebral abscess, the important point to pay attention to subsequently is to see that drainage is satisfactory. Recurrence of headache, vemitting, and drowsiness, with the development of a hernia cerebri, are evidences of imperfect drainage, and the re-accumulation of pus, which must be evacuated at once by passing a knife or sinus forceps along the sinus. Then introduce a larger tube.

Never allow your patient to leave the hospital or pass from your care until the wound is soundly healed.

At the present time, when lumbar puncture is so fashionable, but nevertheless so valuable, both diagnostically and therapeutically, you should always be cautious in employing this procedure in the presence of cerebral or cerebellar abscesses. Had this procedure been employed in either of the two cases referred to to-day, the altered conditions of tension would unquestionably have led to rupture of the abscess into the membranes. If lumbar puncture is employed as a diagnostic measure, be careful, therefore, to withdraw but a very small amount of fluid.

Note.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Arthur Whiting. M.D.Edin., M.R.C.P.Lond., Physician to the Prince of Wales's General Hospital, Assistant Physician to the Mount Vernon Hospital for Consumption and other Diseases of the Chest; Lecturer in, and Dean of, the North-Bast London Post-Graduate College. Subject: "The Peroneal Type of Muscular Atrophy."

A PUBLIC subscription list has been opened in the Isle of Wight with the object of providing a county public memorial of the late Dr. J. Groves, J.P., who was for many years Medical Officer of the rural district of the Isle of Wight, and was actively associated with various public institutions. Dr. Groves was President of the Society of Medical Officers of Health during session 1903-4.

#### ORIGINAL PAPERS.

# THE SALICYLATES IN RHEUMATIC AFFECTIONS.

BY RALPH STOCKMAN, M.D., F.R.C.P.E.,

Professor of Materia Medica in the University of Glasgow; Physician to the Western Infirmery, Glasgow.

It is now generally conceded that acute rheumatism is a specific fever. The prominent part played by the joint affections, owing to the pain and helplessness of which they are the cause, have in the past somewhat obscured the proper conception of it as a general blood infection with local manifestations tending to implicate specially certain tissues and organs, but the high temperature, the leucocytosis, the anæmia, the arthritis, the endo- and pericarditis, and the tendency to natural cure, stamp it as a typical fever with a close general resemblance to many other diseases of the same class. Its duration varies from a few days to three to six weeks. One attack does not confer immunity, but rather predisposes to others. This suggests continued infection such as is seen often in rheumatoid arthritis and tubercle, and sometimes in gonorrhœal rheumatism, where, after periods of latency, the infected person suffers from acute exacerbations. It is probable that many cases of rheumatic infection are very slight; there may be only sore throat with a trifling rise of temperature and some malaise, or it may take the form of a so-called "chill," with no typical symptoms whatever, and rapidly aborting.

In considering ordinary well-marked cases, such as are sent into hospital with the diagnosis "rheumatic fever," it seems to me that two

types may be distinguished clinically. In the first the temperature ranges from 102° F. to 104° F., there is much constitutional disturbance, usually several joints are very swollen and painful, there is abundant sour-smelling acid perspiration, and as the inflammation in one joint subsides, others become implicated in turn. These cases are very susceptible to salicylate treatment; they are of shorter duration, show less tendency to relapse, and are less liable to be followed by

sequelæ than the others. In the second type the joints are not so prominently affected, but the fibrous tissues about the chest, the lumbar aponeurosis, the fascia lata, the periarticular tissues, the tendon-sheaths, and the subcutaneous fibrous tissue are tender and painful, sour-smelling sweats are absent, the temperature is not so high,

and salicylate treatment is not nearly so effective. These cases linger on, relapses are more apt to occur, and sequelæ such as chronic fibrositis and

perineuritis are much more common.

In the present indeterminate state of our knowledge regarding the specific organism of rheumatic fever it is impossible to say whether these are two different diseases, or merely differing clinical types of the same disease. Cases of mild pyæmia, of osteo-myelitis, of gonorrhœal arthritis, and of rheumatoid arthritis, are often, in their early stages at least, very difficult to differentiate from cases of acute rheumatism, and as yet we have no absolute diagnostic such as is afforded by the bacillus of tubercle, or the agglutination test in enteric fever. We have to rely for a diagnosis entirely on clinical experience. In most cases of acute rheumatism it has been found impossible to cultivate an organism from

the blood or joint fluid. It is true that in a few cases diplococci, streptococci, and staphylococci, have been obtained from the blood during life. but bacteriologists are not in agreement as to whether these constitute the primary or merely a secondary infection. Post-mortem, similar organisms are often obtainable from the synovial membranes, the heart valves, and the meninges. Achalme has isolated an anærobic bacillus which he regards as the specific cause, while it has even been suggested that the organism is a protozoon. The reason for this last view is interesting, although possibly not of much weight, namely, that hitherto only protozoon diseases as malaria, syphilis and sleeping sickness, have shown themselves susceptible to drug treatment, while bacteria, in the living body at least, have practically defied specific drugs.

Many competent observers (Singer, Sahli) still hold the view that acute rheumatism is merely a mild pyæmia, and it is quite possible that many cases diagnosed and treated as rheumatic are really pyæmic, but I think we may safely conclude that there is a special non-pyogenic organism, and that it is the cause of a train of distinctive symptoms which go to make up the clinical picture of

acute rheumatism.

From its first introduction into practice it has been almost universally recognised that salicylic acid and compounds from which it can be formed in the body have a powerful and quite specific action in this disease. Some practitioners go so far as to base their diagnosis of a case on its reaction to salicylic treatment. But cases of acute rheumatism react in very different degrees. In some its action is prompt and effective like the crisis in pneumonia, in others it may be slightly slower, or very much slower, and in certain cases the temperature and general condition remain far from satisfactory. Relapses may even occur while the patient is taking the drug. If, however, there is absolutely no beneficial effect, I think we may conclude that the disease is not rheumatic. In some cases the unsatisfactory results of salicylic treatment are undoubtedly due to the dose being too small. When it is increased each time, or a substantial addition such as 40 gr. given once daily, matters often mend at once, and the temperature falls. Apart from this, however, those cases where the fibrous tissues are chiefly affected never do so well as those in which the joints are mainly involved. This is susceptible of more than one explanation. The two conditions may be due to different, although allied, organisms, which are not equally influenced by salicylic acid. There is nothing impossible in this, as in typhoid and paratyphoid fevers, and in human and bovine tuberculosis we have much the same clinical symptoms produced by differing microbes. Another possible explanation is that organisms lodged in the fibrous tissues are more protected, or under more favourable circumstances for continued existence, than those in the blood and joints, and hence offer more resistance to the drug. Certain cases of pericardtis yield very readily to salicylates, while in others they have practically no effect, and in my mind there is no doubt that here we are dealing with different organisms. I do not refer to cases of pneumococcic or tubercular pericarditis, but to those which are clinically and customarily reckoned as rheumatic.

Once the microbic origin of acute rheumatism and its complications and the specific action on

them of salicylic acid are admitted, the logical outcome is to treat cases early and with large doses, in order to kill off the organisms while they are still in the blood and joints, and before they have established themselves in the fibrous tissues from which they are dislodged with very much more difficulty. I believe that "chills" of rheumatic origin are rapidly cured in this way, while those which happen to be of influenzal or other origin derive no benefit from salicylates. The doses need to be large and frequently repeated, partly because salicylic acid is so rapidly excreted, and partly because it is converted into the inert salicyluric acid. There is no danger in pushing it as regards the circulation, which it affects very slightly, its main poisonous action being exerted on the nervous system and respiration. The action of salicylic acid in acute rheumatism is undoubtedly specific. It is of little or no therapeutical value in other febrile diseases, and it exerts no action on the healthy man from which one could infer its action in rheumatic fever.

But besides clinical evidence, the chemical evidence points conclusively in the same direction. Phenol (C<sub>6</sub> H<sub>5</sub>, OH) has no action on rheumatism, but benzoic acid (C<sub>6</sub> H<sub>6</sub>, COOH), a direct derivative, has a very marked effect only inferior to salicylic acid ( $C_6$   $H_4$ , COOH, OH) or ortho-oxybenzoic acid, as it is called chemically. Its isomers meta- and para-oxybenzoic acids are practically inert, although possessed of the same chemical constitution, and only differing in the position occupied in the molecule by the hydroxyl group (OH). No explanation has ever been forthcoming for the cause of this remarkable difference in action. The cresotinic acids (C<sub>6</sub> H<sub>3</sub>, COOH. OH, CH<sub>3</sub>) are all active, the carboxyl and hydroxyl group being in the same relative positions as in salicylic acid. Salicin, saligenin, acetyl-salicylic acid, methyl salicylate, and several other sub-stances are active only because salicylic acid is formed from them in the body, while populin (benzoyl-salicin) methyl-salicylic acid, and dimethyl-salicylic acid, from which no salicylic acid is formed in the body, are inert. Phtalic (C<sub>6</sub> H<sub>4</sub>, COOH, COOH) and toluic (C<sub>6</sub> H<sub>4</sub>, COOH, CH<sub>3</sub>) acids are also quite inactive against rheumatism. So far, no chemical or pharma-cological explanation has been forthcoming of the specific effect of salicylic and benzoic acids in acute rheumatism, while so many closely allied substances are inert.

#### SYPHILITIC FACIAL PARALYSIS.

By Prof. G. MILIAN, M.D.,

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

As long ago as 1830 Dr. Bell described facial paralysis of syphilitic origin, but only in a vague, general way, and it is comparatively recently that its real history has been elucidated.

It is customary to classify cases of syphilitic facial paralysis as early and late, and I shall adhere to this plan, although it is not altogether appropriate.

Facial paralysis is one of the most frequent secondary paralytic manifestations, and it is also one of the earliest, as was shown by Dieulafoy, who, in fifteen cases in which the onset was well marked, met with it once in the seventh month, once in the sixth, once in the fourth, four times in the third, seven times in the second, and once in the first month. It will be seen, then, that it is commonest between the second and the third month of an attack

of syphilis, and it could hardly supervene much earlier than that.

The pathogenesis of this paralysis is much debated. By some it is ascribed to a basic meningitis; by others to gummatous periosteitis of the petrous bone pressing on the nerve, while Fournier, among others, believes it to be a peripheral toxi-infective neuritis.

However this may be, we must certainly discard the idea of a cerebral origin, since the superior facial nerve is attacked just in the same way as the inferior; then, too, the notes of the cases nowhere comprise signs pointing to any cerebral implication, neither hemiplegia nor ictus.

Headache is generally absent, and, as Louste remarks, the cranial pain has nothing to do with the facial paralysis, but is in reality a neuralgic pain in the skin of the cheek and mastoid region, indicative of neuritis rather than an encephalic origin.

There is obviously pressure on the nerve in some instances, but in the majority of cases the cause must be sought, not in any such pressure, but in

toxi-infection.

The rapid disappearance of the muscle and the palpebral reflexes, itself an unquestionable sign of neuritis, by the earliness of its supervention in syphilitic facial paralysis, shows that the nerve is profoundly attacked in its structure, much more rapidly, in fact, than in ordinary compression paralyses.

We may also add the protracted duration of the lesions, because "in presence of osteitic compression the effect of the treatment is usually very prompt. In true lesions of the nerve the duration is much longer if we consider neuritis and polyneuritis occurring in toxic infective diseases similar to syphilis.

Symptoms.—Early syphilitic facial paralysis does not differ in any essential particular from ordinary peripheral facial paralysis a frigore. It may be bilateral.

When it supervenes it attacks forthwith all the branches of the facial nerve, the superior as well as the inferior, so that it presents the appearance of peripheral facial paralysis. It may be accompanied or not by painful sensations.

As a rule the pain is felt, not in the cranium, but over one side of the face, especially in the genio-temporal, auricular, and mastoid regions. It does not correspond to the distribution of the trigeminal, but to that of the facial nerve, and it is generally most acute in the auricular and mastoid regions. The pain presents a characteristic feature—vis., that it occurs in the form of paroxysmal attacks, recurring several times in the course of the twenty-four hours, especially at night, when it may render sleep impossible.

Dieulafoy explains the production of the pain in the area of a motor nerve by assuming the participation of the intermediate nerve of Wrisberg, which is considered by anatomists, on account of its central relations with the nucleus of the glosso-pharyngeal, as the equivalent of a posterior spinal root-in other words, it constitutes the posterior root of the facial nerve, the ganglion whereof is the geniculate ganglion. The paralytic phenomena do not present any distinctive feature. The paralysed side of the forehead is motionless and does not wrinkle, the eye cannot be closed, and remains wide open, or half open, when that on the opposite side is shut; the cheek is flaccid and the zygomatic fold is effaced. The lip is motionless and the labial commissure is deviated to the healthy side; the tip of the nose is also turned to the healthy side, owing to muscular dragging. When the patient opens his mouth to speak and tries to contract his features, the symptoms become much more obvious, owing to the contrast between the immobility of the paralysed side and the contraction of the normal side.

We must also mention epiphora, due to paralysis of Horner's muscle. When there is a lesion of the intra-petrous portion of the facial nerve, in addition to the paralytic phenomena, we get disturbance of taste over one-half of the tongue on the paralysed side, due to paralysis of the chorda tympani, and of hearing from paralysis of the nerves innervating the chain of ossicles.

This form usually runs a mild course, and is soon recovered from. In three or four weeks of mer-curial treatment the symptoms clear up and no trace of the affection remains.

Late Facial Paralysis.—Late facial paralysis is of less frequent occurrence, and it may supervene at any time between the third and the tenth or twentieth year. It is not, like early facial paralysis, due to neuritis, but to pressure on the nerve, either in the Fallopian canal from periosteitis of the petrous bone, or to a patch of sclero-gummatous meningitis at the base of the brain.

The symptomatology of this form is the same as the other, except in cases which are due to paralysis consequent upon meningeal compression. In the latter event it is very rare for the patch of meningitis to be strictly localised to the point of emergence of the facial nerve. The neighbouring nerves are also involved, as a rule, especially the auditory, external ocular, and the trigeminal nerves. When this is the case, lumbar puncture almost in-variably reveals the existence of marked lymphocytosis of the cerebral spinal fluid.

The prognosis in late facial paralysis depends entirely on the date at which the treatment is instituted. If it be commenced immediately on the appearance of the earliest paralytic symptoms, complete recovery may safely be foretold, for the gummatous infiltration has a good chance of clearing up before the nerve has time to become degenerated as the result of the pressure. If, on the contrary, the diagnosis is not made at once, and treatment be deferred, the nerve may undergo complete destruction, in which case the paralysis is, of course, irremediable.

Diagnosis.—The diagnosis of facial paralysis is easy enough. The important point is to ascertain the ætiological factor, and this is often overlooked.

In early paralysis, the presence of other secondary symptoms cannot fail to direct the practitioner's attention to the syphilitic origin of the paralysis, but three or four years after the chancre the facial paralysis may be the only manifestation of syphilitic infection.

When, in a case of facial paralysis, we are unable to elicit any history of sore throat, otitis, fracture of the petrous bone, or recent acute infection, especially zona, we must discuss the possibility of a syphilitic origin, and only admit the a frigore hypothesis as a last resort, should inquiry fail to discover anything pointing to the probability of syphilis. Even so, it may be well to prescribe a course of mercurial treatment. The occurrence of the correlation of the correlation of the correlation of the correlation of the correlation. other paralytic lesions of the cranial nerves along with the facial paralysis is an almost certain indication of a syphilitic influence.

One mistake that should be avoided-and it is easy enough to avoid-is to mistake hemiplegia with facial paralysis for a peripheral facial paralysis, that is to say, for a paralysis of the nerve trunk.

You are all aware that hemiplegia is of common occurrence in the syphilitic, quite at the onset, during the first few months of the infection, just as in the later periods. We must be careful not to take simple facial paralysis for commencing hemiplegia, for that would be a grave error, since hemiplegia implies permanent damage to the patient, whereas facial paralysis ends in recovery, or, in any case, leaves but a moderate degree of infirmity.

The differential diagnosis is easy to make, since the facial paralysis in hemiplegia only involves the distribution of the inferior facial nerve, or, at any rate, is more marked therein. The frontal muscles and the orbicularis are intact, or but slightly affected, and can perform all the movements, provided these be performed in conjunction with the muscles of the opposite side. The non-involvement of the superior facial, therefore, is here an element in the diagnosis. But we must also steer clear of the opposite mistake of mistaking a bulbar hemiplegia for facial paralysis of the peripheral type. You are aware that lesions of the medulla are manifested by total facial paralysis of the muscles on the same side as the bulbar lesion, and paralysis of the upper and lower limbs on the opposite side. We must, therefore, never omit to examine the limbs in presence of facial paralysis, whatever the history may be. This will enable us to avoid overlooking existing hemiplegia, or to assert its existence when it is absent.

# THE MANGOSTEEN TREATMENT OF DYSENTERY.

By MICHAEL AMBROSE, F.R.C.P. AND S.I., Newcastle West.

THE dysentery to which I refer throughout this article is the amœbic or tropical form of the disease; and as I am about to describe a drug treatment of it, practically, if not entirely unknown to the profession, I propose doing so by giving the history of four typical cases taken from clinical notes of some few hundred recorded during epidemics that prevailed in the Far East (Ceylon, Singapore, Penang, Shanghai, etc.), during the late summer and early autumn of last year (1907).

I treated the cases that came under my care for the first few months, or up to the end of August, with the ordinary methods so familiar to us all. Fresh ipecacuanha root, given with its usual auxiliaries, sulphate of sodium or of magnesium in repeated drachm doses, mercury, bismuth, and even quinine, per rectum, as recommended by Osler. However, all these treatments, combined with suitable dietary and rest, proved to be of little avail, most of the non-fatal cases lapsing with time into the chronic form of the disease. I consulted with several medical practitioners at the places which I have named and found them using various cures, one physician even prescribing fresh strawberries, as recommended by certain Continental authorities; but all confessed their inability to cope with the epidemic—people dying by the score after two or three days of hopeless diarrhæa, even in Shanghai, where sanitation tends to the best under the direction of its able Medical Officer of Health, Dr. Arthur Stanley.

On August 24th we took on board at Colombo a Mr. W—, æt. 32, who was travelling round the world in order to recuperate from neurasthenia caused by overwork. He told me that, unfortunately, since his arrival to the tropics in June, he had been subject to diarrhæa of blood and mucus, alternating with constipation, which former had been examined when he contracted the disease in Ceylon and the "amæba dysenteriæ" isolated. When he came under my care he was having what he called one of his "bad weeks" (i.e., constant diarrhæa); so I tried freshly-powdered ipecacuanha, without any good effect, when the mag sulphate treatment had failed.

On arrival at Penang on the morning of the 29th, the patient was in a very weak condition; and during a conversation with the chief officer of the R.M.S. Delta (Mr. Louis Pickney), he informed me that the rind of that excellent fruit, the mangosteen, was used

by natives as a cure for severe endemic diarrhœa. He also told me the way to prepare it for use, and that by adding a quantity of Chinese sugar, it would allay the primary tormina caused by the drug. I got some mangosteen rinds, roasted and powdered and mixed the powder with Chinese sugar in the proportion by weight of two of the former to one of the latter; a powder to which I will again refer to as pulv. mangosteen co. I gave a drachm dose of this compound powder at 9 o'clock p.m. (29th), with similar doses every fourth hour, and the motions though still containing blood and mucus, decreased from an average of 20 to 12 for the following twelve hours; encouraged by this result, I administered drachm doses every third hour until 10 o'clock p.m. (30th), at which hour the patient passed a "formed stool," free from blood and mucus, the first stool that he had passed free from same since the end of June (so I was informed by a male nurse who travelled with patient since he left England); I kept him on drachm doses thrice daily and twice a night until September 3rd, when all dysenteric symptoms ceased and I failed to find the amœba in the stools. On leaving the ship, on arrival at Shanghai next day (4th) he was, according to his own words, "cured." I followed up the case for the following "cured." I followed up the case for the following three weeks, and although he ceased taking the mangosteen toward the end of the second week the dysentery did not recur. Since then I was informed that he returned to England for Christmas, but was not again troubled with the complaint.

The next chronic case is that of an Indian native, Mhd. Mawale, æt. 30, fireman, R.M.S. Delta. This was a very chronic case, extending over nine months, with some dozen intervals of from two to four days; yet the symptoms were never so severe as those of the European passenger. I put patient on pulv. mangosteen co. I dr. doses, ter in die, after first clearing out his bowels well with repeated drachm doses of mag. sulphate, so that the mangosteen would come in direct contact with the bowel. He gradually improved, until on the sixth day blood and mucus had left his stools. Being much worn out by the constant diarrhea I put him on suitable tonics with an occasional dose of mangosteen (pulv. mangosteen co. I dr. every second morning), and am glad to state that within a month he

was restored to perfect health.

As to the acute cases, the most striking that I can select for this article, from amongst several, is that of a Mrs. M. K., æt. 36, European, who came under my care on October 20th, having contracted the disease in Colombo, and the acute symptoms of dysentery appearing on the second day of voyage. I put her, immediately I was called to case, on pulv. mangosteen co., I dr. every second hour for the first twelve hours, with rest and suitable dietary of meat juice and diluted milk. On October 21st the stools had decreased by 25 per cent., and both tormina and tenesmus were much less; I decreased the dr. dose from every second hour to every fourth hour, during day and night, and kept patient on this until the 24th, or fourth day of disease, when the stools lost all signs of blood and mucus, and within a week I failed to find the amœba in the stools. This was amongst the quickest and most decisive cures that I have experienced from pulv. mangosteen co.

As a second acute case, let me select that of a native cook, Abdoonamen Bafaty, æt. 30, who came under my care on September 5th, with very acute symptoms. I put him on suitable dietary and pulv. mangosteen co., I dr. every second hour, as in latter case, for the first twelve hours; when the stools lost a quantity of the accompanying blood and mucus, although they rather increased in number. Towards the end of the second day the tormina and stools decreased, and the latter continued to do so, while administering dr. doses every fourth hour of the compound powder, until on the tenth day of malady blood and mucus had disappeared from the stools; and a search for the amæba proved negative. I put the patient on suitable tonic (mist. ferri.) and occasional doses of the mangosteen every other day until he returned to duty on the 24th of the

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The mangosteen, which belongs to the same family as the apple, grows on a tree named by botanists, Garcinia Mangostane, natural order, Guttiferæ. The tree came originally from Malacca, and in appearance resembles the apple tree very much. It has to be planted about nine years before it yields a crop, but when it does so there are two a year, and continues doing so until forty years of age. I gathered these facts during a visit I paid to a mangosteen orchard near Penang; when the owner, a wealthy native, told me that there was only one variety of the tree, and that the only other country it grows in besides the Federate Malay States is Jamaica, where he had exported plants to some twenty years previously. The fruit has a terra-cotta coloured rind of a quarter of an inch thickness, and of a tough, pulpy consistency, inside which there is the fruit proper, which cannot be better described than by saying it is the exact likeness of the inside of the orange, but white instead of the latter's golden yellow colour. I brought a quantity of the powdered rind to England, as the fruit does not bear such a journey, and submitted it for analysis to Park, Davis and Co., but I regret to say that owing to the time available that the result has not yet reached me from their Detroit Laboratories, U.S.A. I found on later experiments that the pulv. mangosteen is just as, if not more, satisfactory by itself as with the Chinese sugar; the addition of which latter I now regard as nothing more than a native custom and having no effect on tormina one way or the other. The doses that I recommend are up to a drachm every second hour in acute cases, and a half-drachm thrice a day usually suffices for chronic cases.

#### OPERATING THEATRES.

ROYAL FREE HOSPITAL.

COMPOUND FRACTURE OF THE SKULL.-MR. WILL. MOTT Evans operated on a man, æt. 47, who had been admitted suffering from injury to the head as the consequence of a fall in the street. The patient was quite unconscious and could not be roused. On the right side of the head was a wound some three inches in length, with contused edges, and from it was escaping a stream of blood. That part of the skull was obviously depressed below its normal level. The limbs on the right side of the body were somewhat rigid, but those on the left side were completely flaccid. The pupils were unequal, the right being contracted and the left widely dilated; they were both insensitive to light. The breathing was stertorous, and the pulse was full and strong. It was stated that the accident had happened some hour and a-half previously, and that his condition when picked up was practically identical with that at the present time. Immediate operation was decided on, but no anæsthetic was employed. Almost the whole of the head was shaved, washed and cleansed carefully. The wound was then examined: when the finger was introduced it came upon some rough edges of bone, and examina-tion increased the flow of blood. The wound was enlarged by a curved incision so as to form two flaps which were raised from the bone and the fracture was easily seen. It was found that there was a troughshaped depression, mainly longitudinal in direction, situated over the parietal eminence and in front of it. The blood was coming from the anterior part of the depression. An attempt was made to pick out one of the broken pieces of bone, but this proving difficult it was decided to trephine. An inch trephine was taken and the pointer placed on a projecting angle of un-broken bone, and a disc of bone was removed. It was then comparatively easy to take away several neigh-bouring pieces of depressed bone, and others were raised and restored to their former position. Through the opening by the removal of some portions of the bone it was possible to examine the dura mater, and it was seen that nowhere had it been perforated. The it was seen that nowhere had it been perforated. examination was especially careful along the very bottom of the depression; some portions of de-

pressed bone were especially removed from the site of the bleeding, so that the source of hæmorrhage might be examined: the blood was seen to be coming from a small vessel in the dura mater, a branch of the great middle meningeal artery. It was impossible to seize it with forceps in the ordinary manner, but by means of a fine curved needle a silk suture was passed round it and the vessel was tied. No other vessel required ligature. The whole wound was thoroughly washed out with hot normal saline solution and the edges drawn together with silk sutures. rubber drainage tube was placed near the centre of the wound, and a dressing of double cyanide gauze was applied. During the operation it was noticed that soon after the depressed bone had been removed or raised, the breathing had become less noisy and the pulse was distinctly softer when the patient was removed from the theatre.

Mr. Evans said it was obvious from even a brief examination of the man that he was suffering from compression of the brain. The stertorous breathing, the full pulse and the unequal pupils all pointed to this. Since the unconsciousness came on immediately it was probable that the increase of intracranial pressure was due to depressed bone, and not to hæmorrhage, for there is usually an interval of consciousness of some twenty minutes or more between the infliction of the injury and the development of coma when intracranial hæmorrhage is the cause of the compression. The wound in the scalp, and the depression of the vault of the skull both pointed clearly to the site of the increased pressure, but it must always be borne in mind that in some cases two lesions exist, one of which, the more obvious, is not the real cause of the symptoms of compression. In regard to the question of anæsthetic, a patient suffering from compression needs none. The incision in the scalp depends on the case: the old crucial incision is little used nowadays; it gives four flaps to be retracted, and the wound in the scalp coincides with the wound in the bone. When the scalp wound is small the best incision is semi-circular, with the wound somewhere about the middle of the flap so formed, and the base of the flap is directed downwards. This flap is easily retracted, a good view is provided of the injured part, and the incision of the scalp does not correspond with the wound in the bone. In the present case the scalp wound was too extensive to make the semi-circular flap of much use; the wound, therefore, was simply enlarged. For elevating bone it is necessary to find some opening into which the elevator can be inserted; if this cannot be done it is necessary to trephine. It is important to bear in mind that the pin of the trephine must rest on unbroken bone; if attention be not paid to this matter, the pressure needed for cutting the bone will depress still more the depressed bone, and increase of the damage to the brain may result. The question arises: Is it necessary to remove all the depressed bone, or will elevation suffice? So far as possible, it is better to elevate than to remove, for the removal of a portion of the skull leaves a permanently weakened spot. It is necessary, however, to remove sufficient to examine carefully the deeper structures. In the present case the dura mater was not torn, and therefore the risk from sepsis was much reduced. Should the removed bone be replaced? In an aseptic operation it is always desirable to replace as much bone as possible, but when, as in the present case, an extensive scalp wound accompanies the fracture, a certain amount of sepsis is sure to be present, and the risk of necrosing of separated fragments is materially increased; therefore, it is not, as a rule, desirable to replace any fragment of bone which has been completely cut off from its blood supply. Some little difficulty is sometimes experienced in stopping the hæmorrhage from wounded vessels of the dura The expedient adopted in this case, he considered, is the best, where it is not possible to seize the vessel with forceps. The chief trouble is experienced in stopping the bleeding from a meningeal vessel lying completely enclosed in a canal of the bone, as sometimes happens. In a case like this, aseptic wax may be employed, or a small piece of catgut may be

wedged into the opening. Drainage, he thought, is always desirable in cases where a wound has had an opportunity of getting septic. As to the dressing for operation cases which are from the start aseptic, he employs simple sterilised gauze, but for wounds which are septic, or may be septic, he thinks antiseptic dressings are preferable.

The patient began to recover consciousness in three or four hours. He progressed rapidly. The wound healed for the most part by first intention, the tube being removed on the second day. At the end of ten days healing was complete, and the man was allowed to get up. The weak spot in the skull measured about an inch and a-half by one inch, but no protrusion existed. He left the hospital perfectly well three weeks after the injury.

#### TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD JANUARY 13TH, 1909.

The President, Dr. James RITCHIE, in the Chair.

#### CASES.

Dr. George A. Gibson showed (i) a case of cerebral diplegia, with exaggeration of all the superficial and tendon reflexes, and a remarkably characteristic cross-legged gait; (2) a very typical case of acromegaly in a woman, æt. 50. There was the characteristic enlargement of the hands and feet; the lower jaw was enlarged, its angle had become obtuse, and the lower teeth projected in front of the upper ones. The superior maxillæ and the orbital sinuses were also enlarged. There appeared to be enlargement of the thymus gland, and also of the pituitary body; the latter was causing bilateral temporal hemianopsia. The patient was absolutely deaf. There had been no increase in stature; there was no enlargement of any of the hollow viscera. A peculiar point was the presence of swelling of the finger-joints and some muscular wasting of the hands, suggestive of rheumatoid arthritis.

Dr. NORMAN WALKER showed (1) a case of "grouped" comedones. The patient was a young woman, and the comedones were distributed along a diagonal line running over the front of the chest towards the left shoulder and extending down the left arm. He was unable to offer any explanation of the unique distribution. Grouped comedones were usually found in localities where some special cause—the pressure of the collar, or the wearing of a fringe—could be traced. (2) A case of primary sore on the chin of a boy. Besides the large initial lesion two smaller ones were present. (3) An unusual form of tertiary ulceration of the thigh.

Dr. LOVELL GULLAND read a paper on STONEMASON'S PHTHISIS.

He had been led to inquire into the nature of the disease in connection with the operation of the Workman's Compensation Act, the question having arisen whether stonemason's phthisis was a disease due to occupation or whether it was primarily tubercular. In Edinburgh stonemason's phthisis was very common, on account of the freestone so much used in building. It was worked in open sheds, which were very dusty. His material was derived from the statistics of the in- and out-patient departments of the Victoria Hospital for Consumption over a period of four years, during which time routine examination of the sputum for tubercle had been in operation for all cases. During that period 7 masons had been treated as out-patients, and 36 as in-patients. Of the latter, all were tuberculous, as only tuberculous patients were taken into hospital. Of the 7 out-patients, 11 were builders and 76 hewers, showing a marked preponderance among the men who worked in the dusty sheds. Two were not lung cases at all, and one was suffering from emphysema, leaving 55 with definite physical signs of lung disease. Dividing the cases according to age, 1 was under 20, 11 between 20 and 30, 21 between 30 and 40, 33 between 40 and 50, 15 between 50 and 60, and 40 over 60. The maximum incidence of the disease, therefore,

occurred much later than in ordinary pulmonary tuberculosis, which was most common between 20 and 30. Taking the age incidence in in-patients, it was found to be earlier; this was probably because only early cases were admitted. The family history of the patients compared favourably with the other cases treated at the Victoria Hospital. Dividing the cases according to the stage of the disease into mild, with signs of affection of one apex; medium, with both apices affected; and advanced, with signs of excavation; 22 were early, 29 medium, and 29 advanced. Of the in-patients, 7 were early, 3 medium, and 26 advanced. The physical signs in general were identical with those of tuberculous phthisis. The sputum was examined in 54 of the 89 out-patients, and in 37 of 36 in-patients. Tubercle bacilli were present in all the latter, and in 48 of the former; the remainder of the out-patients were either cases who attended only once, or in whom sputum was not obtainable. In considering these 89 cases of stonemason's phthisis, it must be remembered that some of the patients would have contracted tuberculosis in any case, whatever their trade had been; others contracted it late in life, in consequence of their occupation. He believed that all the cases of stonemason's lung were tuberculous.

Dr. Affleck said it was a tradition among masons

Dr. AFFLECK said it was a tradition among masons that the wearing of beard and moustache diminished

the liability to the disease.

Dr. RUSSEIL remarked on the importance of Dr. Gulland's statistics, which were he believed, the first to show exactly the frequency of tubercle bacilli in mason's phthisis.

Dr. Andrew Walker said that in Aberdeen, where granite was worked by pneumatic machinery, mason's phthisis was common.

Dr. Edwin Matthew read a paper on the

ACTION AND USES OF VASO-DILATORS IN HIGH PRESSURE.

Of the numerous medicinal substances—thyroid, benzoates, iodides, etc., beneficial in hypertension only nitrites and nitrates are vaso-dilators. These are only nitrites and nitrates are vaso-dilators. drugs in daily use; they are all powerful vaso-dilators, and their use depends on an accurate know-ledge of their action. He had made a series of comparative observations on liquor trinitrini or nitroglycerin, sodium and potassium nitrite, erythrol tetra-nitrate and mannitol hexa-nitrate. The drugs had been administered to patients with high blood pressure, a regular sphygmanometric obervation had been made in their action on blood pressure, noting the time they took to act, the fall in blood pressure produced, the time of maximum effect, the duration of maximum effect, and the time of return to normal. His results were as follows:-Liquor trinitrini, 2 to 3 minim doses. Action began in 1 minute; pressure lowered by 25-30 mm. Hg.; maximum effect in 5 minutes; duration of lowest pressure 2 minutes; return to original level in half an hour. Repeated doses caused some tolerance to be established. Sodium and potassium nitrite, 2 gr. doses. Action begins in 5 minutes; pressure falls by 32 mm. Hg; maximum action in 15 minutes; duration of lowest pressure, ½ hour; return to original level in 2 hours. Erythrol tetra-nitrate. Action begins in 6 minutes; pressure falls by 32 mm. Hg.; lowest pressure attained in 25 minutes, remains at lowest point for 2 hours; return to original level in 6 hours. Mannitol hexanitrate. Action begins in 15 minutes; pressure falls by 32 mm. Hg.; maximum fall in 100 minutes; lowest pressure acts for 21 hours; return to original level in 6 hours. Vaso-dilator drugs were not curative, but palliative, to stave off advancing hypertension, in the pre-sclerotic stage of arterio-sclerosis. Liquor trinitrini was only useful where brief and speedy action was desired. Pressure could not be permanently kept down by its use, as tolerance was quickly established, and the effect of each dose was so short. Larger doses than 2 minims might lead to unpleasant symptoms. Erythrol tetra-nitrate, given every 6 or 8 hours, was an effective means of lowering pressure. In certain cases of high pressure, however, especially chronic interstitial nephritis, vaso-dilators were useless, as they did not reduce the blood pressure.

Drs. Russell, G. A. Gibson, and Ritchie discussed Dr. Matthew's paper.
Dr. Dawson Turner gave a lantern demonstration

showing some results of

ELECTROLYTIC TREATMENT AND RONTGEN RAY DIAGNOSIS.

Among the slides shown were a number illustrating the healing action of zinc-electrolysis in cases of rodent ulcer, a method of treatment Dr. Turner considered superior to X-rays. Skiagrams showing the diagnosis of pulmonary tuberculosis, aneurysm, pneumothorax, the use of bismuth in the X-ray diagnosis of oesophageal and intestinal mischief, renal calculi, and other medical conditions were also demonstrated.

#### GLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, JANUARY 15TH, 1909.

Dr. WALKER DOWNIE in the Chair.

A SHORT paper on NYSTACHUS, AND THEORIES REGARDING ITS CAUSATION, was read by Dr. W. B. J. POLLOCK. He arranged the various kinds of nystagmus under four heads-namely, (1) congenital, (2) acquired, (3) pathological, and (4) labyrinthine. Congenital nystagmus was in most cases due to some serious defect of vision resulting from loss of transparency of the cornea or lens, or defect in the development of the optic nerve. Acquired nystagmus was usually due to some unhygienic condition of the cornea or lens, or defect in the development of the optic nerve. dition in the occupation, and is commonest in miners and paper workers. It appears to be due to locomotor exhaustion of the muscles of the eyeball. Pathological nystagmus occurs as a symptom of some other disease, such as disseminated sclerosis. Labyrinthine nystagmus is the result of irritation of the labyrinth of the ear, and has some importance in the diagnosis of laby-rinthine diseases. The various theories as to the causation of nystagmus were enumerated, and that propounded by Gowers being put forward as the most probable. Cases were shown to illustrate different varieties of nystagmus, and an interesting discussion followed, in which Dr. W. Syme and Dr. A. Gray made remarks upon labyrinthine nystagmus.

Dr. Jas. F. Gemmill gave a demonstration of the Auriculo-Ventricular bundle of his.

Sections were exhibited by the microscope and by the lantern demonstrating the presence of this interesting muscle in the healthy adult human heart, and also in the fœtal heart of a calf. This bundle of muscular fibres was traced from its passage through the fibrous septum in both directions; one passing to the ventricle walls to end there in the musculo-papillaris; the other end passing to the "Knoten" or nodal point and thence to end in the muscular walls of the auricles, some fibres being traced as far as the cardiac end of the sinus venosus. The presence of two large bloodvessels was shown in the bundle, and the presence of a large number of ganglionic nerve cells was also demonstrated, these being most numerous at the "Knoten.'

Dr. John M. Cowan showed a series of tracings of the venous pulse, illustrating different conditions of alteration in the rhythm of the cardiac wave, which may result from interference with the auriculo-ventricular bundle of His. The tracing showed alteration in the rhythm of the cardiac contractions in various different ways, and demonstrated that disease of the auriculo-ventricular bundle of His was capable of giving rise to irregularities in rhythm of the heart contraction wave, and even reversing the direction of this as in heart-block.

#### ULSTER MEDICAL SOCIETY.

MEETING HELD THURSDAY, JANUARY 14TH.

Sir William Whitla in the Chair.

Dr. R. W. LESLIE read notes and showed a case of pseudo-hypertrophic paralysis in a child, æt. 8. The case was discussed by several members.

Dr. Maguire showed a tumour removed from the axilla of a woman, æt. 60, with microscopic sections for diagnosis. The tumour was a most uncommon one, and opinions as to its nature were widely divergent. Considerable interest has been aroused in it, and specimens will be sent out of Belfast for further

expert opinions on it.
Mr. Howard Stevenson showed a child of 3, with extensive congenital lipomata, and the deformity of giant feet. The case was most interesting and curious, and drawings are to be made of it for the Society.

Mr. A. B. Mitchell read a paper on "A Method of Operating for Varicose Veins," illustrated by photographs. The paper, which will be published later, was discussed by Sir William Whitla, and Messrs. Fullerton, J. B. More, and Howard Stevenson.

Miss Crawford (Lurgan), Dr. R. L. Moore (Bangor), and Dr. Cahill (Belfast), were elected Fellows of the Society, and Dr. Flannigan (Belast) a Member.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

#### FRANCE.

Paris, Jan. 17th, 1909,

OBESITY IN WOMEN.

OBESITY of genital origin in women is closely allied to menstrual troubles or sterility, as all medical men since Hippocrates have remarked. A paper has been just published by Berkovitch in which he has given the conditions under which this genital obesity is observed.

Obesity is frequent in young girls at the period of puberty who are generally anæmic or chlorotic and "irregular." The obesity disappears more or less rapidly as the menses become more regular. Sometimes, instead of adipose tissue, an elastic cedema, un-influenced by the finger-print, is observed. This cedema is more particularly observed on the face in the morning; sometimes around the ankles, especially in the

Another frequent type is post-nuptial obesity, which sets in immediately after marriage, provoked, perhaps, by exhaustion of the ovaries through excessive stimulation; from the same cause obesity is very common in prostitutes, but here, however, alcoholism and the dolce far niente play an adjuvant rôle.

Maternal obesity is no less frequent during the course

of the first months of pregnancy, due, according to M. Charrin, to two or three causes—ovarian and hepatic insufficiency and a certain sluggishness of the oxida-Sometimes the adipose tissue recedes more or less after delivery, but more generally the obesity progresses after gestation, and especially after nursing.

Another well-known type of obesity in women is that observed at the close of uterine activity. Here it is due, not so much to the suppression of the menstrual flux as to the disturbance in the function of the ovaries, and in particular to their internal secretion, which controls the oxidations of the feminine organism. It is thus that, after ablation of the ovaries or surgical castration, obesity has been very frequently observed.

According to M. Berkovitch, obesity of more than half the women is due to one or other of the causes above-mentioned.

The treatment is clearly indicated: preparations of ovarian bodies, powder, or extract, which, according to M. Mace de Lepinay, have produced considerable improvement in many cases.

#### SYMPATHETIC OPHTHALMIA.

Pure sympathetic ophthalmia is caused by propaga tion to the healthy eye of septic uveitis of the diseased eve. The most favourable conditions of this infection is a penetrating wound of the ciliary body, especially when the penetration is accompanied by the presence of a foreign body. Accidental wounds

consequently take the front rank in the ætiology of sympathetic ophthalmia. In some cases, operative wounds (extraction of cataract) might be incriminated as well as perforating ulcer of the cornea, certain intraocular neoplasms, spontaneous cyclitis with phthisis of the globe as a consequence.

The treatment of this affection is simple enough, as it consists in enucleation of the eye; any other opera-tion, according to M. Velude, is absolutely illusory. Evisceration or section of the optic and ciliary nerves, as recommended by Schweigger and Wecker, are not advisable. The operation, which requires but two instruments—an écraseur and a pair of scissors—is of the simplest kind. M. Velude recommends the old practice of passing a thread through the cornea and held in the left hand. By this thread the globe is drawn forward as the muscles are being cut, rendering

unnecessary hooks or assistants.

As to the time of operating, much depends on the nature of the accident and the sensitiveness of the eye. With the modern antiseptic methods, suppressing for the most part infectious complications, an attempt should be made to preserve the organ if no foreign body be present; it should not be sacrificed, however, except where the patient is observed to suffer from repeated attacks of cyclitis. But if the eye continues to be painful, it is better prudence to remove it. Naturally, where the healthy eye suffers, through sympathy, from photophobia, ciliary injection, excessive secretion, enucleation should be performed with-out delay and the other eye treated by mercurial frictions on the forehead, the temples and the arms. Some authors recommend sub-conjunctival injections of sublimate (1-1000).

GERMANY.

Berlin, Jan. 17th, 1009

At the Medizinische Gesellschaft, Hr. Thummim reported the case of a girl, of 17, who first menstruated at the age of 15, but not again. At this period a very luxuriant beard began to develope, hair also grew on the breast and on the linea alba, the voice became deeper, but the figure remained feminine. The external genitals were distinctly feminine, the uterus was normally developed, the ovaries were plainly to be felt under an anæsthetic as small hard substances. The girl died from sepsis, commencing in a panaritium. The autopsy showed the mamme to be well developed, female genitals and a feminine pelvis. The ovaries were small and hard without any trace of ovulation. There were two brown nodules in the right supra-renal body, the left was converted into a tumour the size of a man's fist which proved to be a struma supra-renalis. The thyroid was enlarged, but the hypophyses were not. It was, therefore, a case of atrophy of the germ glands with hypertrophy of those of the vascular system. The speaker thought it would be interesting to study the relationship between the two conditions.

ACUTE OBLITERATING FIBROUS BRONCHIOLITIS.

Hr. A. Fraenkel furnished a further contribution on this subject. He reminded his hearers of his previous contributions, and observed that he had had but few followers. He had observed a total of four cases. The essentials of the affection consisted in this, that connective tissue closure of the bronchioles very quickly took place, i.e., those air vessels that were free from cartilage, that had a diameter of 0.4 to 1 mm., and which terminated in alveoli. The process was similar to that in indurative pneumonia; first there was a fluid exudation in the passages with round cells which became organised and led to closure; in indurative pneumonia, however, the process was limited to the part that was the site of pneumonic infiltration, in fibrous bronchiolitis it was the site of pneumonic infiltration, in fibrous bronchiolitis it was the site of pneumonic infiltration, in fibrous bronchiolitis it was the site of pneumonic infiltration, in fibrous bronchiolitis it was the site of pneumonic infiltration, in fibrous bronchiolitis it was the site of pneumonic infiltration, in fibrous bronchiolitis it was the site of pneumonic infiltration. diffuse, and spread over the whole lung. The alveoli became emphysematous, the emphysema developed wherever the bronchioles were stenosed, and the surface of the lung looked almost like miliary tuberculosis; covered with a large number of small nodules, in which on closer inspection a central depression was to be seen, which was wanting in miliary tuberculosis; the nodules were frequently also smaller or larger than those of that disease. The whole of the appearances was in favour of injury to the lung from respiration, and as a matter of fact in all the four cases, the patients were all young people between 20 and 30 years of age who, from their occupation, were compelled to inhale acids or dust.

On describing the preparations he spoke again of the nodules, which were not rounded, but pointed or angular in form. The process usually began in the wall of the bronchiolus, and passed thence to the alveolar passages, whilst the infundibula of the alveoli remained free, apparently because the bronchial spasm that came on, and later, the connective tissue closure of the bronchioles prevented the entrance of

Clinically, the chief feature was excessive dyspnœa, and cyanosis without any proper dulness; widespread or the lung. The absence of tubercle bacilli in the sputum, and the absolutely negative result of ophthalmoscopic examination prevented any confusion with miliary tuberculosis, in the pneumonia of influenza the dulness was more pronounced, and the sputum also contained the bacilli of influenza. In measles on the other hand there were changes in the lung that appeared to correspond with those of bronchiolitis obliterans, but they were always con centrated in some sections of the lungs, so that death did not result from the hindrance to respiration, but was due to other factors. The disease was sometimes accompanied by high fever and sometimes not, and on two occasions the speaker had diagnosed the con-

dition during life.

From what had been stated the disease was a very serious one. Treatment was powerless; only the inhalation of oxygen gave some relief, and possibly allowed a substance to take place where the exudation was still fluid. On the other hand the prophylaxis was important, and was of course to be directed to the prevention of injury to the lungs from any

industrial occupations.

Several speakers took part in the discussion, amongst them Herren v. Hansemann, J. Lazarus, and Benda.

> AUSTRIA.
> Vienna, Jan. 17th, 1909. EFFECT OF SHOCK.

BENEDIKT presented a male patient, æt. 29, to the members of the Gesellschaft, who was brought to him on November 20th, after hearing sad news, with his head and hip drawn to the right. When the eyes were closed the deformity was increased, and he was in danger of falling towards this side. The patient seemed to have the greatest difficulty to retain his equilibrium owing to his inability to carry the body towards the The right leg was highly adynamic and hyperæsthetic in touch, pain and temperature. This condition was present on the right side of the face and head. The left side was strong and normally sensitive. The left side of the head was painful to percussion. A peculiar combination of erythropsia in the left eye was present, not only for colours, but also white and black. This had existed since the date of the shock, two and a-half years ago. The acuity of vision in this eye was reduced to 6/13. Another peculiarity of this eye was its binocular or double vision, which is rather paradoxical that a double vision could be produced by the simple rolling outwards of the eyeball. It must be noticed also that there was slight insufficiency of the lips on the right side, while the tongue was inclined to the right. In the right eye there was slight ptosis, with insufficiency of the left abducens, which was all that remained of a reputed squint.

The patient had now been three times hypnotised within the present month, the last twice with a metallic magnet under the head. Immediately before the third experiment, he had the patient examined by an oculist, who found all the above phenomena present. The third experiment was then undertaken, with a remarkable transformation. Instead of all being red, he now saw green and red, later yellow, and then blue, and within 27 hours of the experiment no pathological condition of colour was present; within 48 hours no instability or inclination to the right could be observed. A day later the patient seemed as well as ever he had

been before the shock, and expressed himself gratefully for his speedy recovery.
Volumetrical Changes in the Heart.

Heitler finds, by experiments in the laboratory on animals, that when the pressure is equable the volume of the heart increases if the pulse frequency is reduced, but, on the other hand, if the pulse be increased the volume of the heart is reduced. If the

frequency of pulsation be maintained at a constant rate, and the pressure increased, the volume of the heart is augmented, but if the pressure be reduced the converse is the rule. Hence frequency and pressure are interdependent factors in the morbid changes of the heart.

When both frequency and pressure are changed, the when both frequency and pressure are changed, the volume of the heart varies; as by high pressure and reduced frequency, or by reduced pressure and increased frequency, the heart is decidedly increased, so is the cardiac volume increased by increased pressure and reduced frequency, more than if the increased pressure or the reduced frequency existed alone. The same may be said of increased frequency and reduced same may be said of increased frequency and reduced pressure combined, which increases the volume of the heart more than if one of these factors existed. By modifying these combinations, the intensity of results can be neutralised or altered according to the will of the operator.

There are other conditions which also change the volume of the heart, such as compression of the aorta, which slightly increases it, or compression of the vena

Again, infusions of salt injected into the vena jugularis rapidly increase the size of the heart, while irritating the ischiatic nerve has both properties of increasing and reducing the volume of the heart; but irritating the vagus increases its volume, and dividing both of the vagi has the effect of speedily reducing the size of the heart. Injections of strychnia increase the volume, but they have also the property of reducing it. Injections of digitalis increase the size of the heart at first, but subsequently diminish it. Atropin greatly reduces the size, while nicotine increases the size of the heart for a short time, then rapidly reduces it.

SUPRA-RENAL EXTERPATION.

Porges gave an exhaustive account of his experiments on dogs in determining the amount of sugar in the blood. He finds the normal amount of sugar in the blood does not vary with the amount taken into the alimentary canal, nor with bodily labour, but is regulated by a mechanism in the various organs that keeps the saccharine standard of the blood constant. It is only diabetes mellitus, or extirpation of the pancreas, that permanently increases the amount of sugar in the blood. Hitherto we have no morbid condition pointed out that is the antithesis of this saccharæmia, but Porges tells us he has accomplished this in the laboratory with dogs by extirpating the supra-renal bodies. If this hypoglycæmia can be accomplished, as he affirms, we have now reached a permanent cure for diabetes. This removal of the supra-renal bodies and the deprivation of sugar in the blood has caused Porges to closely examine the blood of patients suffering from Addison's disease, which actually confirms his new-born observation in the laboratory. He is now inclined to believe the adynamia of Addison's disease is due to a sort of aglycæmia or paralysis in the hæmopoietic system. This is an important functional change, as the sugar from the blood plays an active part in muscular contraction. The logic of the experi-ment is: We can cure Addison's disease by extirpating the pancreas, and diabetes by extirpating the supra-renal bodies!

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

EDINBURGH UNIVERSITY LECTURES ON THE HISTORY OF MEDICINE.—Mr. John D. Comrie, M.B., delivered the introductory lecture to the first course on the History of Medicine on January 13th. In this preliminary course he intended to treat of the foundations of Western medicine from the earliest times up to the

declining days of the Roman Empire. Beginning with Assyrian medicine, the doctor is mentioned as early as 2700 B.C., and, of the Code of Hammurabi, nine laws relate to the practice of medicine. From incidental references in these, we learn that the operation for cataract was frequently performed, that unqualified persons attempting surgical operations unsuccessfully had their hands struck off; the highest fee allowed was acqual to are of our money, and was not prid if was equal to 25s. of our money, and was not paid if the patient did not recover. Nearly 1,000 of the 20,000 books in the cuneiform library at Nineveh were medical. Letters from consultants to one another were brown and from these was learn that quarrals were not known, and from these we learn that quarrels were not absent among Assyrian doctors. From the Ebers' Papyrus we know that the doctors in Egypt early attained a position of dignity and usefulness. The antiseptic treatment of wounds was carried out by means of a plaster of crocus and essential oils, and poultices, inhalations, and massage were in common use. Tumours were excised by bronze knives; bleeding was checked by the cautery. The sacredness of the human body debarred amputation except of hopelessly shattered limbs, but fractures were set by splints held in place by linen bands. The shapeliness of broken limbs after treatment by Egyptian doctors was moderately good, but did not reach the success of the Greeks in Plato's time, who seem to have anticipated almost

every device known to this branch of modern surgery.

The LATE DR. DEWAR, PORTREE.—Dr. Dewar,
Medical Officer for Portree, and Medical Officer of
Health for the Skye district of Inverness-shire, died at
Portree on Language with officer of the state of Portree on January 12th, after a short illness. He was a native of Easdale, and graduated at Glasgow in 1887; he came to Portree in 1890. During his practice there he had to cope with several serious outbreaks of typhus fever, and his services on these occasions were specially recognised by Lord Balfour of Burleigh, then Secretary for Scotland, and the Local Government Board. Dr. Dewar enjoyed the confidence and esteem of all classes; he was for 15 years a member of the School Board; was a J.P. for the county, and last year was appointed an Honorary Sheriff substi-

tute for Inverness-shire.

THE LATE DR. LORRAINE, HAWICK.—The death is announced of Dr. Lorraine, who for nearly 20 years has practised in the town of Hawick. He spent several years in Colorado and Texas after qualifying, and he recently went out to the Gold Coast to hold a Government appointment for a year. He was Medical Officer to Stobs Camp and the Hawick Post Office. He was a Unionist in politics, and interested in educational and Church affairs. He is survived by a widow and family.

#### BELFAST

MEDICAL MAN FINED FOR CONTEMPT OF COURT .-An interesting incident occurred at Quarter Sessions at Clones, Co. Tyrone, last week, during the hearing of an assault case before Judge Craig. It was stated that the plaintiff had been attended by Dr. Edward Tierney, J.P., of Clones, and his Honour said that he saw Dr. Tierney in court, and suggested that he should be called. The solicitor for the plaintiff said should be called. that his client was a poor man, and could not afford the doctor's fee in the case. His Honour said that if the doctor had been summoned he would have been allowed his fee, but when a medical man was in court he had no privilege more than any other man. Dr. Tierney refused to be sworn, and after persisting in his refusal, in spite of being told by the Judge that it was his duty to give evidence, he was fined £2 for contempt of Court. Dr. Tierney tried to address the Court, but his Honour refused to hear him. He was understood to say that it was not for the sake of his fee he objected, but for the sake of the medical profession. His protest may have been well meant, but seems to have been rather ill-judged and not calculated to raise the dignity of the profession.

DR. TORRENS'S SUPERANNUATION.—At the last meeting of the Belfast Board of Guardians, the question of a superannuation grant to Dr. Torrens, who re-

signed last month, came up for settlement. Dr. Torrens had discharged his duties to the satisfaction of the Guardians for thirty-three years, and it was agreed to grant him an allowance of £185 9s. 1d., being two-thirds of his salary and emoluments.

COLERAINE COTTAGE HOSPITAL AND FREE BEDS.—At the annual meeting of the Coleraine Cottage Hospital, held last week, the question of curtailing the number of free beds in the hospital was discussed. It appears that by the rules any subscriber of £5 to the funds may recommend a patient for eight weeks' free treatment, and this arrangement has resulted in a considerable annual loss. After a lengthy discussion it was agreed, on the motion of Mr. Barrie, M.P., to reduce the period for free treatment to six weeks.

Anti-Tuberculosis Activity.—The vigour with which the crusade against tuberculosis is being carried on in Belfast was indicated by some remarks at the Public Health Committee of the Corporation last week. The Medical Officer of Health said that he thought the visitation of patients after they left the Forster Green Hospital for Consumption was being rather overdone, as at present they were being visited by a representative from the hospital, by a second from the Public Health Department, and by a third from the Women's Health Association! Surely even Lady Aberdeen should be satisfied with this

activity?

QUEEN'S UNIVERSITY OFFICERS' TRAINING CORPS.-A most successful meeting to inaugurate the new movement in the Queen's University of Belfast was held on Thursday evening, January 14th, when Lord Lucas, Parliamentary Under-Secretary for War, attended and addressed the students. The chair was occupied by the Chancellor of the University (the Earl of Shaftesbury), and among the other speakers were the Commander-in-Chief of the Forces in Ireland (General Sir Neville Lyttleton), and Brigadier-General Wilson. The members of the Corps, who now number well over the hundred, looked very smart in their new khaki uniforms, and they and the other students listened with deep attention to Lord Lucas's explanation of the origin and rapid spread of this movement in the various Universities.

#### LETTERS TO THE EDITOR.

OPHTHALMIA NEONATORUM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-I have read with considerable interest Mr. Stephen Mayou's lecture on ophthalmia neonatorum, published in The Medical Press and Circular of December 16th last. With most of his remarks I am in cordial agreement, but a few I find myself unable to subscribe.

It is true that during the last few decades there has been a marked decrease in the morbidity of the disease, but, in my opinion, it is going too far to ascribe this, as Mr. Mayou does, exclusively to the introduction of the Credé method of prophylaxis. Other factors have been at work, the most important of which has been the extension of the antiseptic system to lying-in women and their offspring. Over and over again it has been shown that the mere observance of cleanliness in regard to the baby's eyes, as by wiping them free from discharges as soon as possible after the head is born, is capable of reducing the incidence of ophthalmia to a very low point. Mr. Mayou appears to me to make a mistake not altogether uncommon among ophthalmic surgeons when they set out to dis-cuss the prevention of ophthalmia neonatorum— namely, to view prophylaxis from too exclusive a standpoint, and to pin their faith to Credé's method, somewhat to the neglect of other and equally rational means. On other grounds it becomes difficult to account for Mr. Mayou's omission of any mention of the baby's first bath as a potent means of inoculating the eyes with gonorrhoeal or other germs, and of the precautions that should be adopted to prevent that taking place. His neglect, too, of any mention of the necessity of a separate cot for the infant points in the same direction.

Mr. Mayou claims that "Gibson, of Manchester, was Mr. Mayou claims that "Gloson, of Manchester, was the first to demonstrate that by inoculating pus from a gonorrhoeal ophthalmia into the urethra, a typical gonorrhoea was thereby produced." This is news indeed to me. Benjamin Gibson's famous communication, published in the Edinburgh Medical and Surgical Journal of 1807, dealt mainly with the connection between ophthalmia in the baby and fluor albus in the mother, and with prevention of the disease. It did not describe any such piece of experimental evidence as Mr. Mayou hints at. On the contrary, it was Vetch, who wrote in 1820, who furnished the experimental proof of Gibson's deduction by inoculating the urethra with ophthalmic pus, and thereby inducing gonorrhæa

within 36 hours.

Mr. Mayou rightly points out that ophthalmia neonatorum may be confused with a common condition known as "dacryocystitis neonatorum," due essentially to a congenital imperfection of the naso-lachrymal passages, with subsequent infection. This he speaks of as "really a complication of the disease"—i.e., ophthalmia meonatorum—thereby voicing the view of some of the older writers on the subject. Speaking for myself, I am on record in your columns (THE MEDICAL PRESS AND CIRCULAR, 1899), and elsewhere ("Ophthalmia Neonatorum," London, 1907), as believing that the two affections, ophthalmia neonatorum and dacryocystitis neonatorum, have nothing whatever to do with one another. Although I have examined the secrtion from the affected lachrymal passages in many instances, I have never yet succeeded in finding the gonococcus, as Mr. Mayou claims to have done in an unspecified number of cases (Royal London Ophthalmic Hospital Reports, 1908, January, p. 252). The pneumococcus, on the contrary, is, in my experience, extremely common, and so is the staphylococcus pyogenes albus.

I am, Sir, yours truly, SYDNEY STEPHENSON,

Chairman of the British Medical Association Committee on Ophthalmia Neonatorum

33, Welbeck Street, London, W.

MIND AND BODY.—THE INCURABLES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—Those cases which in ordinary practice are beyond hope of recovery, and where treatment is chiefly concerned in relief of pain and the careful prolonging of life, are as a class rather trying to those who have to treat them. It is natural that the sufferers should turn to others who can offer them any hope, and thus Faith-healing and such other modes of treatment as the honest and qualified practitioner must regard with well-merited contempt, may find some support when imagination may be influenced or ignorance imposed upon. It is strange that we should see, in spite of the great improvements in education, that what Sir Dyce Duckworth says in his letter in the Daily Telegraph (Thursday, January 14th) is possible: "I meet occasionally with astounding credulity in bishops and clergy, in peers, judges, and lawyers, to say nothing of the female sex," is an experience that many of us would confirm. The question of interest is, How has this grown up, and what is the real cause of it? It looks as if there are certain forces that are acting in a deleterious manner on the mental conditions of all classes in this country; and as we generally find that it is from disturbance of bodily health, resulting from unhealthy occupations, improper training of the young, and hereditary ills that these mental defects arise, it would be well that the medical profession should use its influence in protecting the feeble public from the delusions into which it may be led, and to which Mr. Henry Sewill has been so often directing attention in his able letters in The MEDICAL PRESS AND CIRCULAR.

I am. Sir, yours truly, M.D., F.R.C.P.LOND.

January 15th, 1909.

THE APPENDIX: ITS USE, ABUSE, AND ITS CLAIMS FOR PROTECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-The letter of Mr. Rose, the distinguished Emeritus Professor of Surgery at King's College, which you publish this week, is extremely interesting. If the appendix, as we are told, may be looked upon as acting at the junction of the large and small intestine as a special lubricator for the prevention of constipation, "the most usual cause of appendicitis," how can it be good surgery to treat the organ by "establishing an opening through the abdominal wall," and so allowing permanent escape of its lubricating secretions? No one cuts down upon the appendix unless he has made himself as certain as possible that pathological changes calling for its removal exist. If the appendix on exposure should be found healthy it would be left intact; if diseased it would be removed. Where are the records of cases which support the statement that it is good surgery to leave a patient with a fistulous opening through the belly rather than remove the cause of disease. The suggestion that the appendix performs any function of vital importance is not supported by evidence—at least I have not seen any record of cases in which any disability had been set up by its removal. The suggestion that the appendix should be detached and turned adrift to wander in the peritoneal cavity can surely have originated only in the mind of the editor of a lay paper anxious to manufacture startling head-lines. With regard to great newspapers that publish sensational reports, and introduce without warrant the names of distinguished surgeons, all that can be done is for the outraged men to compel the editors to publish their disclaimers of being parties to the transaction. You, Sir, have abundantly shown—this week again in a most suggestive editorial note that we must free our minds from cant in regarding that great institution the British Press. We must recognise that newspaper managers are business men who, before all things, seek to make money, and that in matters medical they do this first, by giving place, and often their endorsement, to the statements of any quack prepared to pay for the advertisement; and, secondly, by publishing grotesque travesties of science, sensational stories to tickle the ears of the groundlings, and draw pence from the pockets of the ignorant populace.

I am, Sir, yours truly, M.B., M.S.

London, Jan. 15th, 1909.

#### EXPERIMENTS ON PATIENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent, George W. F. Robbins, rather reminds one of a legal report which appeared in one of the dailies where the presiding Judge remarked to a counsel engaged in the case, "Mr. So-andso, I do not think you are quite so innocent as you appear to be." However this might be, it seems fairly certain that the statement, "no experiments on patients" would to most minds convey the inference that the hospital adopting such an expression (no other hospital doing likewise) intended to claim on behalf of the public an exemption from "experiments" more or less common to other hospitals. At any rate, to take an analogous case, let us suppose some common boarding-house were to announce on a circular, "No thieves here," I apprehend most of the public would take it that there was less likelihood of their being robbed there than at boarding-houses in general. With regard to Mr. Robbins's advice that other hospitals should follow suit, it is clear if all did the same, that no individual hospital would then gain any special advantage on the one hand, whilst assuming all the hospitals adopted the method, it is possible the announcement would sow broadcast suspicions (much after the fashion of creating false notions in the infantile mind), and which might conceivably turn out to be a greater loss than gain. As Mr. Robbins publicly advises other hospitals to tack on "No ex-

periments on patients," may I take the liberty of suggesting to him the advisability of ripping it off, taking the suggestion for what it is worth?

I am, Sir, yours truly, CLEMENT H. SERS.

Brighton, January 16th, 1909.

RHEUMATOID ARTHRITIS AND ENGLISH HOTELS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-Whilst agreeing in the main with Dr. Murrell on this subject, permit me to say that I think his adverse comments on English hotels, in comparison with those on the Continent, unnecessarily sweeping. In his letter in your last issue he says:—"The great objection to our English health resorts is the expense necessarily incurred at anything like a decent or socalled first-class hotel. At many of these they refuse during the season to quote inclusive terms even for a prolonged stay, and 25s. a day is the average charge for room and board, even when that room is at the top of the house and of the size of a fairly capacious wardrobe." I have a pretty extensive knowledge of hotels both in this country and abroad, and if he will pardon my saying it, I have never yet come across an establishment at any of our health resorts, where such exorbitant terms were demanded. I know Bath, Buxton, Cheltenham, Matlock Bath, Brighton, Torquay, and Hastings well, and have staved within the last five or six years at the largest and what are considered the best hotels of nearly all these places. the Royal Hotel, Matlock Bath, which is much frequented by the profession and by patients because of its splendid system of baths, I was asked but 15s. per diem by the week for an excellent bedroom, full board and attendance. At the Grand Hotel, Brighton, I paid but 18s. in the height of the season, and at the Queen's Hotel, Hastings, a little less for the same accommodation. Of Harrogate I cannot speak from personal experience; but I need not enlarge on the subject except to say that I fear we are too prone to send our patients abroad, when in many cases they would do better at our health resorts at home.

I am, Sir, yours truly,

M.R.C.P.LOND.

January 18th.

#### OBITUARY.

#### DR. B. S. BOOTH.

THE oldest member of the medical profession in Newry has just passed away in the person of Dr. Biabazon S. Booth, at the advanced age of 79 years. Early in life he adopted the medical profession, and in 1858 he went to India, and was shortly afterwards appointed House Surgeon and Secretary to the native Hospital at Calcutta. This appointment he held for six years, when he became Civil Surgeon at Tirhoot. On his return to Ireland in July, 1874, he was elected Medical Officer of the Newry General Hospital, and that position he held until March, 1894, when he resigned owing to failing health. On the occasion of his retirement he was made the recipient of an address and presentation from the people of Newry for the care and attention he had always shown the patients at the hospital.

#### DR. J. D. CRONIN, M.B.

WE regret to record the death of Dr. J. D. Cronin, of 75 Lower Mount Street, Dublin, at the advanced age of 87. The deceased was formerly a Fleet Surgeon in the Royal Navy, and retired from active service some years ago. He had received the Medal for the Bellin Commission. for the Baltic Campaign, 1854-5.

MEASLES is raging at Bromyard, Herefordshire, and all the Council schools have been closed. Nearly 200 cases have been reported.

## Summary of Recent Medical Literature, English and Foreign.

: pecially compiled for THE MEDICAL PRESS AND CIRCULAR.

A Digest of 265 Cases of Malignant Disease of the Uterus, treated in the New Hospital for Women.—
Louisa E. Anderson and Kate Platt (Journ. Obst. and Gyn., Vol. XIV., No. 6). During thirteen years, 265 cases were treated. Of these there were 217 cases in which the disease affected the cervix, and 48 cases in which it effected the funder. The records of the which ite disease anected the cervit, and 40 cases in which it affected the fundus. The records of the cases of malignant disease of the cervix in which hysterectomy was done show that in seven years, 1895-1901, the abdominal route was employed in 2, and the vaginal in 25 cases; whereas in the following six years, 1902-1907, 58 abdominal and only 2 vaginal hysterectomies were performed for the same conditions. At first the abdominal operation differed little from that done for fibroids. At the present time the method consists of the removal of the uterus and appendages, the broad ligaments and the upper part of the vagina, the uterine arteries being divided well outside the line of the ureters. If the condition of the patient permits, a systematic search for and removal of lymphatic glands is carried out. The incision in the vaginal roof is left open, and a gauze drain passed through to drain the large cellular space, which is opened during the operation. This method of draining has been modified in some of the recent cases, and the vagina only drained, but the results have not been favourable; there has been more tendency to cystitis, and in some cases blood clot has collected and cellulitis resulted. After vaginal hysterectomy patients used commonly to die from local recurrence in the vaginal vault. Out of the 29 cases in which vaginal hysterectomy was done for cancer of the cervix, the disease recurred in 12 cases in the vaginal scar within a few weeks from the time of operation. After a complete abdominal panhysterectomy, metastasis is most likely to affect the iliac glands. Hence the importance of their removal at the time of operation, if possible, and even in those cases in which it seems as if satisfactory removal has been accomplished, the patient may develop symptoms of internal recurrence a year or two later. Of the 29 patients upon whom vaginal hysterectomy was performed for cancer of the cervix, one is alive and well seven years after the operation; two remained well for two years, and in 12 the disease recurred very soon after the operation; the other cases have been lost sight of. The after-results of 58 abdominal hysterectomies for cervical cancer, though not good, are much better than the vaginal operation. Twentyare much better than the vaginal operation. Twenty-six cases are alive and well between 1½ and 4 years after operation, 11 cases had recurrence within a year, 6 cases recurred in from 1 to 3½ years; 15 cases cannot be traced. The after-results of fundal cancer are much more satisfactory. Nine cases were operated on per vaginam, and 30 by the abdomen; of these, 26 have remained well for from 2 to 7 years; 7 developed recurrence in from 1 to 5 years; 3 patients died, and 7 cannot be traced. A large number of the cases of fundal cancer—17 out of 27—were associated cases of fundal cancer-17 out of 37-were associated with fibroids, while in cases of cancer of the cervix this association was relatively rare, only occurring in 4 cases out of 216. The large proportion of cases of cancer of the endometrium which were accompanied by fibroids in the uterine wall suggest that it is necessary to regard all 6 beside with a case. sary to regard all fibroids with suspicion and to advise their close supervision and their removal as soon as they cause symptoms. By far the greater number of specimens of carcinoma of the cervix are of the squamous-celled variety. The authors say:—"It is surprising in how many cases careful search is rewarded by the finding of one or more well-defined whorls, and on more than one occasion this has determined the inclusion among the epitheliomata of a tumour which might otherwise have been described as columnar carcinoma. The tumours of the fundus columnar carcinoma.

consist entirely of adeno-carcinomata, of which all varieties are present. The authors point out that the vast proportion of women with cancer of the cervix are over 30, and have had children, while the majority of those with cancer of the fundus are over 50, and have not had children, but there are exceptions to both rules.

Physiological Anæsthesia During Labour.—Dr. R. E McKerron (Journ. Obst. and Gyn., Vol. XIV., No. 6) records an interesting case under this heading. He was called to a woman in her fourth confinement. Labour began in the forenoon, at 5 p.m. the os was almost half dilated. At 7 p.m. the membranes were ruptured and the head at once descended and engaged the os. The pains became frequent and strong, and were attended with so great suffering that he decided to give chloroform earlier than usual. However, before the anæsthetic could be begun an unusually strong pain came on; at its height the patient gave a loud scream and at once became unconscious. Her breathing was heavy and almost stertorous; her face somewhat flushed; the eyes fixed in a vacant stare; the pupils dilated, but equal; the conjunctival reflex completely abolished. She was quite insensible to pain, but in all the limbs reflex movements could be elicited. There was no muscular twitching at any time, merely general and complete relaxation. Powerful uterine contractions, accompanied by strong down-bearing efforts, continued to occur every three minutes. The coma remained unaltered, and the conjunctival reflex absent till delivery was completed. Immediately the child was expelled she suddenly woke up, consciousness being regained almost as abruptly as it had been lost. There was no mental confusion, but she remembered nothing, had felt no pain, and was surprised to learn that the child was born. The same writer reports a case of fatal hæmorrhage from the vagina in a newborn child. On the fourth day after birth there was a slight discharge of blood from the vagina. The hæmorrhage continued, but was little more than a stain and did not seriously affect the child. On the eighth day the bleeding increased, and on the following day was comparatively profuse. Cotton wool soaked in adrenalin was passed into the vagina, but did not arrest the bleeding. The next morning the child was blanched and pulseless; several diapers had been soaked with blood from the vagina, while from an insignificant scratch on the lip over a drachm had been lost. The vagina was plugged with cotton wool and the bleeding ceased, but the child died a few hours and never any sign of intestinal hamorrhage. No reliable family history could be obtained, but the mother stated that she suffered from eachymosis on the slightest injury. That fact and the bleeding from the scratch on the lip place the hæmophilic nature of the case beyond doubt.

The Subcutaneous Catgut Suture.—W. E. Fothergill (Journ. Obst. and Gyn., Vol. XIV., No. 6) has, by way of experiment, used the subcutaneous stitch for closing every incision made by him during the past year, with the exception of one or two emergencies. The result is that he has formed a definite conclusion to the effect that this method is a trifle better than any other which he has tried or has seen. He sums up the advantages as follows:—(1) It is rapid as compared with other methods; (2) it leaves a less conspicuous scar; (3) there are no stitches to be removed; (4) if suppuration occurs it is merely superficial and does not affect the deeper portions of the wound. The risk of hernia is

thus diminished; (5) suppuration is less likely to occur in this than in any other form of suture. The source of infection, at the present time, is generally the skin of the patient. In the subcutaneous suture, apart from the incision itself, only two holes are made through the skin. This fifth advantage is the most important and the one on which the writer wishes to base his suggestion that the subcutaneous continuous suture is worthy of extended trial by all abdominal surgeons.

Treatment of Fractures of the Base of the Skull .-Maclaren (Brit. Med. Journ., 26th December, 1908) describes two cases of this injury. The author considers that fracture through the petrous portion of the temporal bone, opening into the external meatus, is most likely to be followed by septic infection of the cranial cavity. He uses dry boric acid to keep the external ear and meatus in an aseptic state. As the powder dissolves in contact with the discharge, it cannot form a retaining plug. The writer recommends trephining in basal fractures. The continual oozing of cerebro-spinal fluid is an important factor in the evolution of septic meningitis; nor does it establish a water way to the interior of the skull, but it produces a sodden state of the tissues very favourable to sepsis. A trephine opening and drainage of the subarachnoid cavity prevents the fluid being under tension, and allows it to escape by an arranged safe route. Tension is equally relieved by as spinal as by a cephalic drain, but in head injuries there is a practical advantage in placing it at the seat of the injury, in that it allows an investigation of the skull and brain at that point which is likely to have suffered from the direct violence. The opening for drainage is large also, and not liable to the blocking which may easily close a small tube as used in lumbar puncture.

Appendicostomy in Diffuse Septic Peritonitis.— Billington (Brit. Med. Journ., 9th January, 1909) points out that in his experience, and in that of many others, it is often impossible to introduce into the circulation the large quantities of fluid recorded by Murphy, of Chicago, in cases of diffuse septic peritonitis, where it is important to prevent peristalsis by withholding all fluid and food by the mouth. In such cases, the writer has utilised the appendix for the purpose of introducing fluid into the large bowel with marked success. For instance, in peritonitis following the perforation of a gastric ulcer, an incision is first made over the lesion, which is treated and drained through the wound. Then, instead of making a suprapulic puncture to allow of the introduction of a rubber tube into Douglas's pouch, the abdominal cavity is again opened by a small vertical incision over the lower part of the right rectus. The appendix is pulled out, the distal portion cut off, and the stump fixed to the upper angle of the wound. A small rubber catheter is passed into of the wound. A small rubber catheter is passed into the cacum, the other end projecting through the dressings, when they are put on. A large rubber drainage tube is passed to the bottom of Douglas's pouch through the lower part of the wound. In bed, the patient is placed in Fowler's position, the catheter being connected to a tank containing warm salt solu-tion, and which stands on a table at the bedside, and not more than three inches above the plane of If the peritonitis is due to disease of the appendix, the part nearest to the cacum is often comparatively healthy, and if not a small portion of the carcal wall nearest the surface is sutured to the skin. Not more than one pint per hour is admitted into the bowel to avoid distension. When absorption ceases, as much fluid is evacuated from the rectum as is introduced into the cæcum, and the supply is then cut off. The catheter is not left in longer than forty-eight The mucous membrane of the stump of the appendix is then removed, and the opening closed by uniting the sero-muscular coats. Finally, any adhesions between the skin and the stump are gently broken down, and the latter allowed to tetract. The advantages of this procedure are: The quantity of fluid admitted can be regulated exectly, and the whole large intestine takes part in its absorption. The patient suffers practically no discomfort. Stimulants and nutrients can be rapidly administered.

#### REVIEWS OF BOOKS.

DISEASES OF THE HEART. (a) This is the most recently translated volume in 'Nothnagel's Practice." Of text-books on diseases of the heart there are many which are excellent and sufficient. Unfortunately, some of the best are by foreign authors, and as many medical men are unable to read any language but their own it becomes necessary to have these works translated. In the original it has been recognised by specialists as an authoritative treatise on its subject. Prof. von Jürgensen writes on cardiac insufficiency, endocarditis, and valvular disease; while Prof. Krehl treats of diseases of the myocardium and nervous affections of the heart. The section on diseases of the pericardium has been entrusted to Prof. von Schrötter. These three names are a sufficient guarantee as to the excellence of the monographs comprising this volume. Turn where we will, we find the same painstaking care in statements of facts and theories in evidence.

As regards the work of translation, this has been carefully carried out by the American translator. We have taken the trouble to compare at random one or two passages with the original, and find that the translation is accurate, and represents in a wonder-fully pleasing manner the sense of the writers. Few alterations or additions have been attempted. the most part these consist in adapting the medicinal nomenclature to the United States Pharmacopæia. A few matters of interest, published since the original work was issued, have been added in brackets. These include important American and English contribu-tions to the subject. As a work of reference on diseases of the heart, we feel certain that this volume will take its place alongside the other excellent English treatises on the subject. It presents all that is best in German teaching, and knowing as we do the thoroughness with which the original writers are in the habit of carrying out their investigations, we have no hesitation in claiming for this translation a hearty welcome by specialists in this country. This, the latest volume in the English edition of "Nothnagel's Practice," is a noteworthy addition to a most excellent series, which is certain to make its influence felt upon English teaching and practice.

THE RECTUM: ITS DISEASES AND DEFECTS. (b)
This very fine volume is the lineal successor of a former and smaller work published by Sir Charles Ball in 1887 on "The Rectum and Anus, their Diseases and Treatment." The latter work is now out of date and has been withdrawn from circulation. The present volume is an entirely new book on the same subject, but upon different lines. It is founded mainly on the Lane Lectures on Diseases of the Rectum which were delivered by the author at San Francisco in 1902, and on the Erasmus Wilson Lectures on Adenoma and Adeno-carcinoma of the Rectum, delivered at the Royal College of Surgeons in London in 1903. The result is a concise work which, while it deals most fully with the modern aspects of its subject, does not digress into historical matters which, though interesting, are unessential.

The book begins with a well-written chapter on rectal anatomy, in the course of which the author acknowledges the work which has been done in the Dublin School of Anatomy in recent years in regard to the lower bowel. The chapter is illustrated by some very beautiful original drawings made from frozen sections and dissections. Then follow three

<sup>(</sup>a) "Diseases of the Heart." By Prof. Th. v. Jürgensen, of Tübingen: Prof. L. v. Schrötter, of Vienna; and Prof. L. Krebl, of Greifswald. Edited with additions by Geo. Dock, M.D., Professor of Medicine and Clinical Medicine, University of Michigan. Authorised

cine and Clinical Medicine, University of Michigan. Authorised translation from the German, under the editorial supervision of Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Philadelphia: W. B. Saunders Company. (b) "The Rectura, its Diseases and Dovelopmental Pefects." By Sir Charles B. Ball, M.Ch., F.R.C.S.L., Hon, F.R.C.S.Log., Regius Professor of Surgery in the University of Dublin; Surgeon to Sir Patrick Dun's Hospital; Hon. Surgeon to the King. London: Henry Frowde, Hodder and Stoughton. Pp. xiv and 328, with five plates and 181 illustrations in the text. 1998.

chapters on developmental defects, many interesting specimens of which are shown in the illustrations. An interesting but, perhaps, rather short chapter on rectal diagnosis follows. We note that the author is sceptical as to the value of the rectoscope and the colonoscope for the diagnosis and treatment of highlying disease of the rectum.

The chapter on infective diseases is longer. In addition to the more ordinary forms of infective disease, gonorrhœa, diphtheria, tuberculosis, syphilis, and actinomycosis of the rectum are discussed. Fig. 59 has been accidentally reversed. There is a fine microphotograph of spirochate pallida, obtained from an anal condyloma. The next six chapters are devoted to ulceration, fistula, stricture, fissure, and prolapse. We look with interest for the author's opinions on the radical treatment of rectal prolapse. We note that he considers that the modern improved methods of operation give such good results that all patients, save decrepit old people, should be advised to submit to operation. Van Buren's lineal cauterisation is sometimes of use. Narrowing of the anus by circular cau-terisation, or by plastic operations is an unscientific and unsatisfactory way, as is Thiersch's operation. "It cannot, of course, be claimed that any surgical procedure can completely restore the relaxed muscles and ligaments of the pelvic outlet; recent methods, however, show that, as in nephropexy and hysteropexy, much may be done by fixation of the rectum or colon, either alone or in conjunction with myorraphy (? myorrhaphy) of the levator ani, and narrowing of the lumen of the rectal ampulla by rectoplicature."

The next three chapters deal with piles, and are, as one would expect, excellent. The pictures, also, are very good, Plate IV. being especially fine. The next four chapters deal with benign and malignant tumours and their treatment, The various operations per-formed for rectal cancer are described fully and well illustrated.

The remaining chapters of the book deal with colotomy, foreign bodies in the rectum, injuries, neuroses, pruritus ani, and diverticula. In the chapter on pruritus the operation originally described by Sir Charles Ball is detailed and illustrated. It has proved of considerable benefit, not only in the hands of its originator, but in other hands also.

We heartily congratulate Sir Charles Ball both on the originality and merit of his work, and on the beauty of the idlustrations. The book reflects the greatest credit on the Dublin School of Surgery, as well as on its distinguished author.

### MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

At the quarterly meeting of the Council, held on Thursday last, Mr. Henry Morris, President, in the The formula for a new by-law relating to the admittance of women to the examinations for the diplomas of Fellow and Member and of the Licence in Dental Surgery was submitted, and was referred to a committee to take into consideration and report thereon to the next meeting of the Council. A vote of thanks was passed to Mr. E. L. Gruning for his gift of skulls from Cook Islands of pathological as well as of anthropological interest. Mr. Henry T. Butlin, F.R.C.S., was re-elected a member of the Court of Governors of the University of Birmingham. Having passed the required examinations and conformed to the by-laws, Mr. Norman Cecil Rutherford, M.B., B.S., Edinburgh University and London Hospital, was admitted a Fellow of the College. Diplomas of the College Licence in Dental Surgery were granted to the following successful candidates: -Thomas Percy Brown, Birmingham University; Robert Hope, Harvard University and Guy's Hospital Dental School; Joseph Jackson Wardill, Charing Cross and Royal Dental Hospitals; Hugh Parry Williams, Middlesex and National Dental Hospitals; and Augustus Vallack Wallis, Charing Cross and Royal Dental Hospitals. Alleged Abortion at Cardiff.

THE Cardiff Deputy Stipendiary (Mr. E. M. Jones) on January 14th proceeded with the charge against Henrietta Veall (45), of having unlawfully used an instrument on Clara Lamprey on divers dates between July and November, with intent to procure a miscarriage. Mr. Harold Lloyd defended. Mrs. Lamprey, who seemed weak, appeared in court for the first time.

In the course of her evidence, Mrs. Lamprey said that her husband, Adam Lamprey, was a carpenter. She had known defendant for about four or five years, and in July last she met her in Canton and told her she was enciente. Prisoner told her that she would call next morning, and, in fact, did call, and visited her every day for nearly a fortnight. During her operations Mrs. Lamprey said that some days she felt sharp pain. After she ceased to visit she felt very ill, and lost a quantity of blood for about three weeks or a month. Eventually she was compelled to take to her bed, and sent for Dr. Campbell. A monetary arrangement had been arrived at with the prisoner, who told witness that she usually received a guinea. She was paid about 18s. in all.

Cross-examined by Mr. Harold Lloyd: Had you made up your mind to get rid of the child at all costs? -No, I had not thought of it until I had a conversa-tion with her.

Emma Sellers, a widow, referred to a conversation she had with Mrs. Lamprey some six or seven weeks before prisoner was arrested. The prisoner used to call at Mrs. Lamprey's on several days. When prisoner

came witness used to go away and leave her. Amelia Phillips, a servant girl. also gave evidence to the effect that she had seen prisoner calling at the house.

Dr. Hy. Campbell said that he was first called to visit Mrs. Lamprey on November 1st. He examined her and found her in a high state of fever. He afterwards made an examination in consequence of what she told him, and took for granted that there had been a miscarriage through abortion. He questioned her on that, gave her medicine, and treated her. On November 11th he was of opinion that she was dangerously ill, and not likely to recover, and her depositions were

taken, and an operation was performed on the 14th.

The prisoner was committed for trial at the next Assizes.

Mussels and Typhoid-Atherton Medical Officer's Report.

An outbreak of typhoid, which lately assumed serious proportions, has occurred at Atherton, and in a report which Dr. Marsh, the Medical Officer for the district has submitted to the District Council on the matter he says:—"In 13 cases we found that the sufferers had partaken of mussels. The time or period of the year, I take it, is no excuse for a typhoid epidemic, though there is no doubt that the disease occurs more frequently in the autumn, and, in all probability, the cause of this is the abundance of flies which are in evidence at that time. In the present year, for instance, the number of flies at or about the end of September amounted to a perfect plague. In the light of present knowledge with respect to the danger of eating mussels, etc., it seems advisable that greater powers should be given to the county and local authorities to deal with any such food that is found to carry any disease, or as likely to cause disease. It seems hard that persons should contract typhoid from eating shell-fish, etc., which come from a river or bed known to be affected by sewage, and yet even the county authorities have not control over that river should it happen to be tidal. I am informed that in almost all cases the patients who had partaken of mussels suffered from the disease in a very severe form, and of these patients there have been four deaths, or rather more than 26 per cent. of the cases attacked."

The Peculiar People.

BEFORE Mr. Justice Grantham, at the Central Criminal Court on January 12th, George Hornsnell, a labourer, and his wife, Eliza Hornsnell, of Plaistow, members of the Peculiar People, were

put upon their trial charged with the manslaughter of their daughter Phyllis, aged 4 years, by wilfully neg-lecting to call in medical aid in time of illness.

Mr. Symons, counsel for the prosecution, said the sect did not believe in medical aid in case of illness, but rather in the efficacy of prayer. The child Phyllis was one of eleven children, and on November 29th she was seized with measles, followed by pneumonia, from which she eventually died. It was admitted that, with the exception of calling in a doctor, the parents did everything they could for the child. When the pneumonia set in on December 5th, according to the usual practice of the sect an elder was called in, and the child was prayed over and anointed. A week later the parents invoked the further assistance of the elders, and a special prayer was offered up in their church. On Decmber 17th, however, the child died.

Martha Worm Wild, the wife of an elder, spoke as to the child's illness, and to calling in her husband to pray over and anoint the child.

The Judge: Could you not have prayed over her?-

I did, and God heard my prayer.

The Judge: But the child died. Why did you not call in a doctor?-We act upon the words of St.

James.

The Judge: Our Saviour did not tell you not to call in a doctor, and you appear to place more reliance on the words of an Apostle than upon the words of our Saviour.—Witness replied that she had not read in the Scriptures that Christ told them to call in a doctor.

The Judge: Christ said, "They that are whole need not a physician," which seems to infer that those who

are not whole do.

Dr. Kennedy expressed the opinion that the child's life with medical aid would certainly have been pro-

The jury found both prisoners guilty.

The Judge sentenced each prisoner to three months' hard labour.

#### Hospital Tragedy.

AT Chelsea Mr. C. L. Drew conducted an inquiry regarding the death of Charles Stephen Welch, a patient at Brompton Hospital for Consumption, who threw himself out of a window with fatal results.

Annie Maria Bayes, a sister at the hospital, said that Welch was a very nervous patient. As he said he wished to go home, witness told the porter to be on the alert to prevent him from leaving. Afterwards he became more rational. There were no bars to the windows in the wards, which were always kept open for the sake of the open-air treatment of patients.

William Thomas Beasley, porter at the hospital, stated that on Saturday morning, about 9 o'clock, he was put outside Welch's ward because the man was supposed to be out of his mind. Witness was told to prevent him from leaving the ward, a window in which was open. Suddenly the sister called to witness, and he saw Welch trying to get out of bed. Witness advised him to lie down, and covered him up. Suddenly he bounded out of bed and sprang on to the window-sill, but witness managed to catch him by his shirt and one of his wrists. The sleeve of his shirt, however, tore right off, and he fell into the yard 40 ft. below. Witness believed the man was insane.

The Coroner: Can you say why an insane man was

allowed in a ward with an open window?--I cannot. Dr. McNalty, Resident Medical Officer, said that when he saw Welch he did not think that there was

anything mentally wrong.

The jury returned a verdict of death from misadventure, stating that the deceased man jumped from a window not knowing what he was about.

### Society for Relief of Widows and Orphans of Medical

AT the Quarterly Court of the Directors of this Society, held on Wednesday last, Dr. Blandford, President, in the chair, the deaths of three members were reported, among them being that of Sir Henry Pitman, a Vice-President of the Society. A vote of condolence

to Lady Pitman was passed from the Chair. Three new members were elected. A sum of £528 had been distributed among the annuitants of the charity as a Christmas present, each widow receiving Lio, each orphan £3, and each orphan on the Copeland Fund 65. Since the last Court one of the annuitants of the Charity had died, her husband had paid in subscriptions £33 12s., and died in 1855, since that date his widow received from the Society in grants the sum of £3,300, a striking instance of the advantages of joining the Society. The sum of £1,242 10s. was voted for the half-yearly grants to the widows and orphans at present on the books of the Society.

Relief is only granted to the widows and orphans of deceased members, and during the past three months five letters had been received from widows of medical men, left penniless, asking for relief, but this had to be refused as their husbands had not been

members of the Society.

Membership is open to any registered practitioner, who at the time of his election is residing within a 20-mile radius of Charing Cross. Full particulars and application forms for membership may be obtained from the Secretary, at the offices of the Society. 11 Chandos Street, Cavendish Square, W.

#### Doctor's Death on a Liner.

DR. ALEXANDER HENRY McDougal, the son of a Manchester alderman, and a Medical Officer in the service of the Holt Steamship Company, of Liverpool, was found dead in a berth of the liner Zaanstroom at Hull. He was returning to England from Amsterdam, where he had arrived after a voyage to the West Coast of Africa. He had been ill for some time, and a brother had come to Hull to meet him.

#### Royal Army Medical Corps.

THE following appointments were officially gazetted

on Friday last:

Surgeon-Lieut.-Colonel F. W. Gibbon, from the Tyne Division (Electrical Engineers) Royal Engineers (Volunteers), to be Lieutenant-Colonel, with precedence

(Volunteers), to be Lieutenant-Colonei, with precedence as in the Volunteer Force, April 1st, 1908.

1st London Territorial Division.—Surgeon-Lieut.—Colonel and Honorary Surgeon-Colonel J. Cantlie, M.B., F.R.C.S. (Eng.), from the Honorary Coloneloy of the Eastern Command, Maidstone Companies, and the London District, London Companies Royal Army Medical Corps (Volunteers), is appointed to the Honorary Colonelcy of the division, with precedence as in the Volunteer Force, April 1st, 1908.

#### Conjoint Examinations in Ireland.

THE following candidates have passed the First Professional Examination of the Royal College of Physicians and the Royal College of Surgeons, January, 1909:—M. J. Ahern, A. T. Cannon, T. F. Collins, H. J. Cotter, C. J. Hegarty, C. Hennessy, C. F. D. Kelly, F. Mulcahy, A. Verling.

#### Measles Epidemic in Nottingham.

THERE is an epidemic of measles at Nottingham. Evidences seem rather to point to its further increase. The significant point about the present visitation is that it has spread most during the period at which the children have been absent from school, for it is usually urged that the closing of schools is the most effective method of checking the spread of these infectious diseases.

So far the Nottingham Education authorities have only found it necessary to entirely close one school, but several of the infant departments and classes for younger scholars, in all parts of the city, are temporarily suspended.

THE members of the Blackwater Fever Expedition of the Liverpool School of Tropical Medicine have now returned to England. The expedition consisted of Dr. J. O. Wakelin Barratt and Dr. Warrington Yorke. The expedition left England on August 12th, 1907, and returned on the 5th inst., remaining in Nyasaland for fourteen months.

#### NOTICES TO CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Instial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January let and July let respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messra. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12. Messra. Dawson and Sons are our special agents for Canada.

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ADVERTICEMENTS.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.:—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

M.R.C.S., L.R.C.P. (Londou).—As such posts can always command a supply of candidates from young qualified men, without payment, it is obvious that the offer of an honorarium is not regarded as a necessary feature in the case.

"XRAYARR."

#### "XRAYSER."

The flexibility and adaptability of our language in meeting the demands of the times, are illustrated again in the suggestion that the man who works with the X-Rays should be called an "Xrayser." The man, too, who practices Mr. Keetley's operation, might be called an "Appendicoster."

SUBBITON FRACTITIONER.—We see no objection to your name being published as Hon. Secretary of the entertainment—especially as there is a joint secretary and the proceeds are for a medical charity. Why not write for an opinion on the point to Dr. Bateman, Medical Defence Union, Trafalgar Square, London, W.C.

ERYTHEMA NODOSUM.

A correspondent has written to ask if erythema nodosum occurs elsewhere than on the legs. In a case recently under his care there were apparently typical swellings over the legs, but he was somewhat doubtful about the diagnosis as there was a similar swelling on one thigh near the groin, and both ears were swollen and one was excertated Erythema nodosum ma- occur on almost any part of the body, as well as on the legs. It is often accompanied by other forms of erythema.

BBDFORD .-- Your communication came to hand as we were "at

B. K. G.—The matter is one of so controversial a nature that we cannot open our columns to its discussion in the form of an anonymous communication. If our correspondent, however, is prepared to append his name to his letter, we will publish it.

### Meetings of the Societies, Tectures, &c.

Wednesday, January 20th.

Rotal Society of Medicine (Section of Anesthetics) (20, Hanover Square, W.).—8.30 p.m.: Special General Meeting: To Consider the Advisability of Legislation to Control the Administration of Anesthetics. The proposed Bill, which is given in full in the British Medical Journal, Dec. 5th. 1996. Supplement p. 302, will be taken as the basis of the Discussion. North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

British Balneological and Climatological Society (20, Hanover Square, W.).—5 pm.: Dr. Buckley (Buxton): Intestinal Lavage on the Plombleres System.

ROTAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.).—8 p.m.: Right Hon. Lord Avebury: On Seeds, with Special Reference to British Plants (Presidential Address). Exhibition of Forsminifers dredged from off the Coast of Somaliland.

Therrich (Permatological Section) (20, Hanover Square, W.).—4 p.m.: Annual General Meeting. Clinical Case: Dr. Pernet: A Case of Granuloma Annulare (shown at a previous meeting). (And other Cases not yet notified.)

ROTAL SOCIETY OF MEDICINE (Neurological Section) (20, Hanover Square, W.).—8.30 p.m.: Short Papers: Dr. A. E. Russell and Mr. P. W. G. Sargent: Apoplectiform Cerebral Hemorrhage; Operation: Execuation of Blood; Recovery. Dr. Henry Head: A Case of Fractured Spine illustrating Various Forms of Sensory Loss. Dr. S. A. K. Wilson: A Case of Thrombosis of the Left Posterior Inferior Cerebellar Artery.

NORTH-EAST LONDON POST-GRADUATE COLLEGe (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynscological Operations (Dr. A. E. Glies). Clinics: Medical Out-patient (Dr. A. J. Whising); Surgical (Mr. H. W. Carson); T.-Bays. 5 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture: Square. W.C.) —6 p.m.: Chesterfield Lecture: Paratuberculides (due to Tuberculous Toxins): I., Macular; II., Papular; III., Pustular; IV.. Pigmentary.

FRIDAY, JANUARY 22ND.

BOTAL SOCIETY OF MEDICINE (SECTION FOR THE STUDY OF DISEASE IN OHILDREN) (20, Hanover Square, W.).—5 p.m.: Cases: Dr. T. R. Whipham: (1) A Case of (7) Lymphadenoma; (2) Case of Congenital Cystic Disease of the Kidneys, Paper: Dr. David Forsyth: Infant Mortality as seen in a Children's Hospital—being an Analysis of 1202 Consecutive Infant Deaths under One Year as the Evelina Hospital for Sick Children.

ROYAL SOCIETY OF MEDICINE (EPIDEMIOLOGICAL SECTION) (20, Hanover Square, W.).—8.30 p.m.: Paper: Dr. Hamer: Some Bacteriological Problems considered from an Epidemiological Point of View.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.50 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

#### Appointmenis.

Hospital, Greenwich, has been appointed Secretary of University College Hospital.

M.B.Lond., L.R.C.P.Lond., M.B.C.S., Assistant Medical Inspector of Schools by the Somerset County Council.

County Council.

BIGGS, GEORGE NIXON, M.B., B.S.Durh., Aural Surgeon to the Evelina Hospital for Sick Children.

BROWN, W. BRODIE, M.D., C.M.Aberd., Medical Officer and Public Vaccinator for the Parish of Lumphanan.

CORBETT, WILLIAM EDWARD MANDERSON, L.R.C.P. and Medical Inspector of Schools for Stonehouse by the Devon Education Committee.

FREMANTLE, F. E., M.B.Oxon., D.P.H.Eng., to the Edward Jenner Lectureship on Public Health at St. George's Hospital Medical School.

School.

HOWARD RUSSELL, M.S.Lond., F.R.C.S.Eng., Surgeon to the

HOWARD RUSSELL, M.S.Lond., F.R.C.S.Eng., Surgeon to the Poplar Hospital.

MARNAN, JOHN. M.B., B.Ch., B.A.O.Dub., Medical Officer at the Gloucester County Asylum.

SANDFORD, GEORGE CALROW, M.D., C.M.Edin., Public Vaccinator for Devonport.

TCHATROVSET, BARBARA, M.D.Lond., Assistant School Medical Officer by the London County Council.

#### Vacancies.

Sussex County Hospital, Brighton.—Stephen Ralli Memorial.—
A Pathologist.—Salary, £350 per annum, and half the fees earned in private practice. Applications to the Secretary of the Hospital.
London Fever Hospital, Liverpool Road, N.—Assistant Resident Medical Officer.—Salary, £150 per annum, with residence and board. Applications to the Secretary.
Bristol General Hospital.—Senlor House Surgeon. Salary, £120 per annum, with board, residence, etc. Applications to the Secretary.
Bolton Union.—Resident Assistant Medical Officer.—Salary £170

Bolton Union.—Resident Assistant Medical Officer.—Salary, £170

Bolton Union.—Resident Assistant Medical Officer.—Salary, £170 per annum, with furnished apartments, light, washing, and attendance. Applications to H. I. Cooper, Clerk to the Guardians, 28, Mawdsley Street, Bolton.

Manchester Corporation.—Monsall Fever Hospital.—Senior Assistant Medical Officer. Salary, £200 per annum, with board, lodging, and washing. Applications to the Chairman of the Sanitary Committee, Public Health Office, Town Hall, Manchester.

Surrey County Lunatic Asylum, Brookwood, near Woking.—Second Assistant Medical Officer. Salary, £200 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent of the Surrey County Lunatic Asylum, Brookwood, near Woking.

Epileptic Colony, Langho, near Blackburn.—Medical Superintendent. Salary, £250 per annum with furnished residence, washing, and garden produce, etc. Applications to Henry Woodhouse, Clerk to the Joint Committee, Chorlton Union Offices, All Saints, Manchester.

#### Marriages.

CLOTHIER—Francis.—On Dec. 19th, at St. Andrew's Church, Calcutta, Henry, eldest son of Henry Clothier, M.D.Lond., of Innerwyke Manor, Felpham, to Elsie Francis, daughter of Mrs. Laidlaw, 44, Prince's Gardens, S.W.

MONEY—LEALE.—On Jan. 13th, at St. Sampson's Church, Guernscy, Lleut, Brien Money, R.N., son of the Rev, Granville Money, Rector of Byfiest, to Florence Mary, daughter of Josish Leale, M.R.C.S., of Vale House, Guernscy.

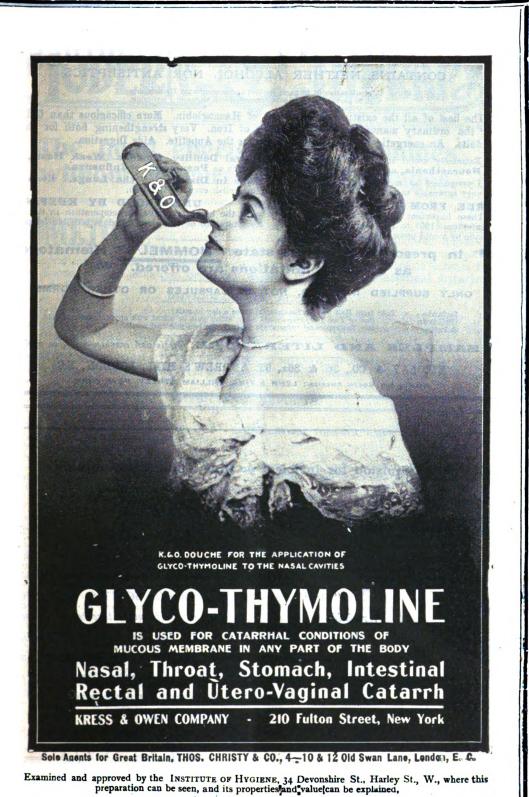
MACANDEW—WIGMORE.—On Jan. 13th, at St. Like's, Chelsea, William D. Macandrew, son of the late W. Macandrew, J.P., of Westwood, Colchester, to Grace Nins Wigmore, youngest daughter of William Wigmore, M.R.C.S., L.R.C.P., of Inverness Terrace, London.

#### Deaths.

COPLAND.—On Jan. 16th, at Sheerness, John Brightman Copland, M.R.C.S., L.R.C.P.Lond., aged 29.

NOBLE.—On Jan. 16th, at 167. Kennington Park Road, London (suddenly), James Black Noble, M.R.C.S., L.R.C.P., aged 50.

SPICER.—On Jan. 13th, overtaken by an avalanche, near Lenserheide, Switzerland, Dr. John Evan Spicer. aged 33 years, son of Mr. and Mrs. Evan Spicer, of Belair, Dulwich.



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PROFESSOR HARE reports: "The physiological action of Brometone is nearly identical with that of the older bromides. It is efficacious in small doses."—Practical Therapeutics.

#### PHYSICIANS' REPORTS.

#### Epilepsy.

W. Kempster, M.D., Emeritus Professor of Mental Diseases, Wisconsin College of Physicians, reports eight cases, some grand mal, some petit mal. "In all, the action of Brometone was prompt and characteristically sedative. In no case did it cause nausea or disturbance of the skin. The improvement in physique and mentality in all cases was marked."—Therapeutic Gazette, Feb., 1906.

W. P. SPRATLING, M.D., Superintendent Craig Colony for Epileptics, describes a case in which the face was one mass of sores from taking bromide for ten years. "I stopped the bromide and put him on Brometone. The effect was almost miraculous. In nine weeks, the skin cleared up, the eyes brightened, and the attacks dropped from 5 or 7 per month to 1 in three months."—New York State Journal of Medicine, Oct., 1906.

Dr. Joy, with an experience of over 50 years in the treatment of epilepsy, after prescribing Brometone where other treatment failed, states that its effects far exceeded his expectation, stopping the paroxysms almost at once and permitting discontinuance in four months or less.—Canadian Practitioner, June, 1907.

#### Headache, Neurotic Conditions, etc.

J. J. Kyle, M.D., writes: "In cases where we wish the nervous mechanism to receive rest and not be merely drugged into insensibility, Brometone seems to produce a condition similar to physiological rest, and its effects are not cumulative. It is well borne in the gastric irritation due to alcoholism, and is specially indicated in over-stimulation of the nerves by excessive brain work and in congestive headaches."—Medicine, Sept., 1904.

#### Insomnia, Chorea, etc.

In a series of 20 cases, Brometone proved an excellent sedative in mild excitement and insomnia, also in slight nervous affections of children and adults. In children aged six years, 2 grains thrice daily gave good results in chorea and epilepsy.—Medical and Surgical Monitor, June 15, 1904.

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H. ERICHSEN, M.D., reports the case of an epileptic, 44 years of age to whom Brometone was administered daily for more than a year without any indication of "bromism," and with improvement in physical and mental conditions.—Medical Age, Sept. 25, 1904.

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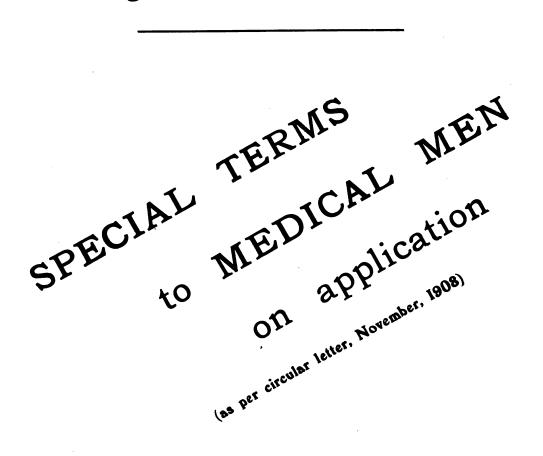
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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, JANUARY 27, 1909.

No. 4

## Notes and Comments.

THE exclusion from most London and The English many provincial hospital posts of all Colleges and but holders of the Fellowship of the Hospital Posts. English College of Surgeons, or the Membership or Fellowship of the London College of Physicians, is a grievance of old standing. It has been brought once again into the field of medical politics by the conjoint forces of the Irish Graduates' and Schools' and the Scottish Medical Diplomates' Associations. The meetings held last week in London were restricted to the medical profession, but the matter is clearly one that will have to be settled by the governors of hospitals, and possibly by Parliament. It is extremely unlikely that the English Colleges will stir a finger towards a reform which will disturb the nice little monopoly which they now enjoy. On the other hand, the governors make and unmake hospital laws, and it is only right that their attenrion should be drawn to a condition whereby, so it is alleged, many good candidates are excluded from

The Arguments.

competition.

Most of the arguments are on the side of those who object to the exclusion, and that is natural enough, for it is not the way of monopolists

to argue-they simply sit tight and listen in silence. One point likely to impress lay governors is the fact that a large number of successful Scotch and Irish graduates, not to mention members and associates of the English Colleges and holders of other excluded degrees and dip-lomas, are engaged in private practice. They are, therefore, good enough to attend the hospital governors, but not sufficiently well educated to attend hospital patients. Let the governors reflect before they issue any more advertisements for candidates with an English college higher diploma; they are simply proclaiming to the world the inferiority of the private medical attendants of a large section of the community. We are glad to learn that University College has joined several other large Hospitals in throwing open the staff appointments. That, at any rate, is a logical inference, however remote it may be from the minds of those who advertise such posts in the Times and other daily journals.

WHAT do the English Colleges What is give in return for this monopoly? So far as can be seen on the surface, they take all they can the "Quid pro Quo? " get and give absolutely nothing in return. The hospital posts are divided between the Fellows of the Surgeons' and Members and Fellows of the Physicians' Colleges. So finely woven are the meshes of the monopoly that members of the Royal College of Surgeons and licentiates of the Royal College of Physicians are

left out in the cold with all the rest of the qualifying degrees and diplomas. It is to be hoped that the matter will always be discussed in a temperate and reasonable spirit. Several distinguished Irishmen were present at the London meeting, notably Sir Charles Ball and the Presidents of the Irish Colleges of Surgeons and Physicians, Mr. Lentaigne, and Dr. Horne. It is much to be regretted that none of the leading Scotch college men were represented at a movement in which the interests of their diplomates are so closely concerned. Professor Glaister, President of the Faculty of Physicians and Surgeons of Glasgow, was, unfortunately, prevented at the last moment from attending. We shall await with interest the further action of the conjoint Scotch and Irish committee.

A "Beauty Specialist."

News comes from America of the death of a Dr. Woodbury, who is said to be the pioneer of "beauty specialists." The unfortunate man, who had amassed a large fortune,

committed suicide, so that it is invidious to criticise him or his cult. We do not know how far he was regarded as an orthodox practitioner in America, where such wide laxity in medical ethics prevails, but as he advertised in all the New York trams and ran a "Facial Culture Company," he was what would be regarded here as the most objectionable type of quack, namely, the renegade doctor. A side of the charlatan's life which the general public, and even the medical profession, as such, hear but little of, is that which deals with failure, and though Woodbury was successful in some of his treatments, his failures were many and serious. Disappointed ladies assaulted him, alleging that their appearance was ruined for life, and legal actions for damages were several times brought against him. Yet the game went on and the money rolled in, for only a few days before his death he paid as much as £10,000 for a piece of property. One is tempted to draw from this career at least one lesson, namely, that the type of man who is a successful charlatan is the "bluffer," the man of unlimited self-assurance and power of throwing dust in the eyes of others, but that there is generally a limit to the powers of keeping the deception up. and when that point is reached, ruin or shame or disgust crush a spirit which seemed proof to all impressions. Under such circumstances self-destruction is the natural corollary.

JUDGE WILLIS is certainly supersed-Hoar-Frost ing Mr. Plowden as the licensed joker of the Bench; at any rate, he for the Complexion. is being boomed by the press in that capacity, and Mr. Plowden is hardly ever quoted now. We cannot say that the jests which he is reported as making are of the side-

splitting variety; indeed, they seem to belong rather to the senile order, but they are duly chronicled by obsequious journals as if they were the utterances of a very Sydney Smith. An adjourned case was before His Honour last week, in which a firm of druggists sued a "Dr. Paget, of Oxford Street, in respect of a quantity of ointment called "hoar-frost," which had been supplied to him to sell to ladies as an application for the complexion. At the previous hearing much merriment of the judicial order—had been made over the use of the stuff, and over the alleged fact that the hoar-frost turned into a chalky substance when the box containing it was left open. In the result the defendant lost the case and had to pay, but the fact that interests us is, that a gentleman holding the position of a judge should think that it is part of a medical man's business to trade in face-creams and such preparations for the complexion. Needless to say, there is no "Dr. Paget of Oxford Street" on the Medical Register, and at whatever university he may have laboriously succeeded in graduating, it is not one recognised by the General Medical Council. It is no more part of a medical man's practice to sell face-creams than it is of a barrister's.

THE Birmingham Vegetarian Society One Acre had the rich treat last week of enjoyand ing addresses from one Dr. George a Cabbage. Black and a Mrs. Cobden-Saunderson, who boasted that she had known the inside of one of H.M.'s gaols for disorderly conduct as a suffragette. In their hands the gospel of green food was exalted to a pitch so giddy that one cannot be surprised that its equilibrium was unstable. Dr. Black was armed with figures in regard to infantile mortality and kindred subjects that made the flesh creep, and, needless to say, that the nasty habit of eating meat was largely responsible for these disasters. Saunderson took the question a stage further by placing it on an ethical level, though she was "not blind to the inconsistency of the vegetarian who condemned the slaughter of animals for meat, yet wore boots, shoes, and gloves, and ate cheese into which rennet entered." Certainly, when one dives into these subjects, with the ethical notion alone to guide one, some very odd and inconvenient consequences are encountered. The lecturer proceeded to show the eating of fruit would reduce crime—or, rather, to assert that it would, for we rather fear it might conduce to cannibalism-and bring ruin to brewers. The peroration soared into a perfervid sphere, and denounced three acres and a cow as the final apotheosis of man. What was wanted, she said, was one acre and intensive culture! And at that we may well leave it.

Reward for First Aid.

THE men and women who give up a considerable portion of their time to study first aid do so, as a rule, with the entirely unselfish desire of benefiting their fellow-creatures, and it is

certain that if they looked for fee or reward for their efforts they would find themselves almost uniformly disappointed. It is all the more satisfactory, then, to be able to record that in the case of one man who by his knowledge of ambulance work, was instrumental in saving a fellow-workmen's life, has been rewarded. The incident occurred at the Tredegar Company's power-house at Pochin Colliery, some two months ago, a workman coming into contact with a live wire and being nearly electrocuted. Fortunately a man named Joseph Marsden was at hand, and by performing artificial respiration he

was able to restore the patient, and in recognition of this act his fellow-workmen subscribed and presented him with a gold medal. When the small amount of practical good done by the ambulance classes held throughout the land is commented on, it is well to record incidents of this kind, and of their appreciation by those most immediately concerned.

#### LEADING ARTICLES.

MONOPOLY AND HOSPITAL APPOINT-MENTS.

Last week a conjoint meeting of the Irish Medical Schools' and Graduates' and the Scottish Medical Diplomates' Associations was held in London. The object was to discuss the old-standing grievance of the exclusion of the holders of Scotch and Irish qualifications from most of the important London and many of the provincial hospital appointments by making the possession of a higher diploma of one of the London Royal Colleges an indispensable condition of tenure. The result is to confer a valuable monopoly upon the Fellows of the Royal College of Surgeons of England and the Members and Fellows of the Royal College of Physicians of London. It should be carefully noted that so cribbed and strictly defined is this monopoly that it actually excludes the members of the College of Surgeons and the licentiates of the College of Physicians, not to mention graduates in medicine and surgery of London and provincial Universities. The practice referred to doubtless began in times when, in England, at any rate, the two English Colleges held the field. Its survival into present times, however, constitutes an anachronism of a peculiar and, in many ways, a most objectionable nature. Nowadays there are a number of excellent medical schools scattered throughout the United Kingdom where students can obtain a first-rate education, and qualify subsequently at British Universities, or at one of the Scotch or Irish corporations. These gentlemen, although holders of a State qualification, will, for the most part, find themselves debarred in later life from a chance of holding hospital posts that are admittedly essential to the attainment of a high standard of excellence in professional life. Clearly, their exclusion is an excellent thing for the English Colleges, inasmuch as it gives their alumni the practical monopoly of the important hospital posts in England, and compels many holders of provincial qualifications to take their diploma simply and solely for the purpose of opening the door to a desirable appointment. It is hardly likely that the English Colleges will take any steps towards putting an end to a state of affairs so favourable to their own interests. The matter is one for the medical profession generally, for the lay public and the State to inquire into and, if necessary, to remedy. So far as the medical profession are concerned, their verdict has been unanimous in condemnation of the exclusion of certain qualifications from hospital appointments. The medical journals agree also. The British Medical Association has emphatically recorded its disapproval on several occasions. The Irish Graduates' and Schools' Association has been fighting the injustice for the last twenty years, and is now joined by the Scottish Medical Diplomates'

Association. Various provincial hospitals, on being fully informed of this invidious condition, have thrown open the posts to all comers. The Lords' Committee of Inquiry into the London hospitals advocated the open door to all qualifications. short, wherever an appeal has been made to any authoritative public body, professional or otherwise, the favoured college clause has been invariably condemned. The English Colleges will probably attempt to evade the issue by saying the exclusion is none of their doing, but rests with the governors, who make the rules of the hospitals. That is true so far as the legal responsibility is concerned, and the matter will have to be referred eventually to the public for settlement. Meanwhile, the united Scotch and Irish Associations have very wisely opened the campaign by a calm and dignified appeal to the exercise of justice and fair play of their professional brethren. When the matter is clearly placed before the public there can be little fear as to the ultimate verdict that will be given. existence of a class monopoly of the kind is hopelessly out of touch with the democratic spirit of modern times; and so, too, for that matter, is the antiquated and irresponsible government of the qualifying corporations. The question of preferential privileges to certain licensing bodies, indeed, forms one of various anomalies that sooner or later will have to be dealt with by the State in the interests of the community. Were the General Medical Council constituted on a representative and business-like basis, a class privilege of this kind would receive prompt attention. It is to be hoped that the conjoint Irish and Scotch Associations will induce the British Medical Association to take up vigorously this vexed question of monopoly in hospital appointments.

#### CURRENT TOPICS.

#### Compulsory Irish.

THE war over the question of compulsory Irish in the new National University goes on gaily in the columns of the daily papers, and it appears likely that it will go on in spite of the fact that the Catholic Hierarchy has issued a statement, in which they point out the inadvisability of compulsion at present. From a medical point of view the question is interesting, first, because it has been seriously suggested that a knowledge of Irish is of more value to the average medical man than a knowledge of French and German; and, secondly, because it is suggested that the University should not accept any substitute for their own matriculation examination, because to do so would enable candidates to enter without showing their knowledge of Irish. Again, at the back of all, and apart from the actual question as to whether or not Irish should be compulsory, is the knowledge that, if the University authorities once yield to popular clamour, their independence and their power of academic action is gone for ever. At present, the position to the outsider resembles a deadlock, as whichever party gets its way it seems as if the result would be disastrous to the University. It will be hoped the Senate will from the beginning show strongly that it is not to be influenced by clamour, and that the Irish-speaking party will consent to waive their

sentiments out of regard for the material interests of their country.

A "Pampered" Medical School.
Under the heading, "Pampered Medical Schools," a contemporary, which delights to pour contempt on medical men and medical work, records the donation to the School of the London Hospital of £20,000 to endow medical research. As the medical schools of the London hospitals are practically unendowed, and as most of them can hardly make two ends meet, without applying any money to encourage original research, the fact that one of them receives £20,000 for the highest purposes that mankind can pursue, hardly supplies the justification that the schools are "pampered." We most gratefully acknowledge the noble disinterestedness of the donor, who not only wishes to remain anonymousand therefore is not a candidate for New Year or Birthday honours—but has given the money during his lifetime, and so made a personal sacrifice. But, knowing the pressing need for the extension of scientific knowledge about disease and diseaseprocesses, medical men cannot but wonder that the rich and philanthropic give, and even give generously, to objects which relieve suffering, and yet hardly open their purses to subsidise the prevention of suffering. No doubt we have to thank the antivivisectionists largely for this perverted idea of humanitarianism, and if it gives them pleasure to know that they are the cause of much of the most poignant misery in the world, they may take what comfort they like out of the reflection. Hospitals, after all, only deal with the results of evils, and it will not be till we know, and can remove, the causes that produce those evils, how they can be recognised in their earliest stages, and how nipped in the bud, that substantial progress will be made in promoting the welfare of mankind. Till the ground is cleared and facilities are granted for abundant organised research into these factors, we are frequently only administering pills for earthquakes. All the more honour, then, to the noble-hearted and clear-minded gentlemen who, like the anonymous benefactor of the London Hospital, brave the snarls of the antihumanitarian and give their money to this great cause.

#### Wrong Medicine.

WE confess to considerable sympathy with a nurse who gives a wrong dose of medicine to a patient in hospital, as it is obvious that, while human nature remains as frail as it is, such mistakes will occasionally occur, and whereas in most other callings a similar error would do little or no harm, in that of a nurse the consequences are apt to be most serious. Indeed, the only person with whom we have more sympathy is the unfortunate patient, who, looking on the nurse as his trustee, takes what she gives him with confidence. An occurrence of the kind took place at an asylum quite recently in which a senior nurse, before going off duty, seems to have instructed her subordinate to give patients their medicines according to colour-dark red to so-and-so, light red to so-and-so, and green to a third. At the inquest which followed, the Coroner remarked that this was a happy-go-lucky method of doing things, and we cannot say the epithet erred on the side of harshness. The patient actually died of chronic bronchitis, and the medical man in charge was able to say that he was satisfied that the administration of 1½ grains of morphia, which the patient had actually received, had in no way accelerated death. The Coroner, in censuring the head-nurse, said that it was "lucky" for her that death had not been caused by the mistake; and, indeed, it was. But the most incomprehensible part of the affair is, what would have happened to the right patient if he had had 1½ grains of morphia administered to him?

The "Property Doctor."

A CORRESPONDENT writes us to protest against the way in which the medical practitioner is handled in fiction. He is treated, says our protestant, like the lay figure in an artist's studio, in the sense that he is arbitrarily placed in a certain-possibly ridiculous, or, at any rate, improbable-attitude, and is left there until altered circumstances necessitate modification. In accordance with the requirements of the plot, he is represented as preternaturally sagacious and prophetic, albeit exceedingly indiscreet, or he is roughly delineated as a blundering fool. Feminine authors, it must be conceded, usually deal tenderly with the family doctor, whom they endeavour to render sympathetic, though in the process he is apt to become a trifle stodgy, not to say Mrs. Gampy. Or, circumstances permitting, we are treated to the type of the "ladies' doctor," a being quite apart, who pats duchesses on the cheek with a familiarity begotten of intellectual superiority, and associates a sort of Sherlock Holmes' insight in the matter of diagnosis with the (supposed) manners of a man of the world, blase by much success. Male authors are much less scrupulous; they smack the doctor on the back, à la Hall Caine, and, with unwarrantable familiarity, make him utter opinions and volunteer advice with a regrettable lack of logic and discretion. worst offender, however, is the pseudo-medical writer, he who somehow or another has lived in actual contact with medical oracles. In French literature he is simply unutterable, whether he credits the practitioner with a prescience unknown in practice, or, on the contrary, triumphantly emphasises his least pardonable weaknesses, à la Leon Daudet. Pathology in fiction is fearfully and wonderfully made, for the symptoms are stricken with incoherence and accorded unauthorised significance. Patients display the most disconcerting alternations of delirium and perspicacity; they are dying one minute and are abominably active the next; in fact, there is a lamentable uniformity of morbid conditions. After all, the most tiresome literary products are those in which none of these faults is committed, novels in which every symptom is accurately described at great length, along with the treatment, and the doctor, by his prolixity, is depicted as an insufferable bore.

Dirty Dublin.

WHEN, last winter, we had occasion to call attention to the inadequate manner in which street-cleansing in Dublin is performed, we were speedily brought to book in the Dublin Corporation on the initiative of a medical member, who had our remarks referred to the Cleansing Committee for report. We regret to note that this winter matters

are in even a worse condition than heretofore. The streets are left ankle deep in mud, and when the winds of March come, we may look for even more than the usual supply of street dust and horse manure to be whirled into bedroom windows. Incidentally, we may mention that we are glad to find our critic of last year calling attention in the papers to the present scandalous condition of affairs. As regards the public health, Dublin has had a peculiarly bad year, culminating a week or two ago in a mortality rate of 29 per 1,000. There has been an epidemic of typhoid which the health authorities were unable to explain, although it is not improbable that some of the misplaced activities of the Corporation were responsible for it. Moreover, apart from this epidemic, which was limited to one district, the incidence of the disease through the city generally has been heavier than for some years back. It is not reassuring, therefore, to find that the municipal authorities are as careless as ever with regard to their duty of cleansing the streets.

Mortality among Medical Men.

According to its custom, our contemporary, The Journal of the American Medical Association, has, in its first issue for the new year, analysed the deaths of medical men recorded in its columns during the past twelve months. The total number of deaths of medical men in the United States and Canada, recorded during the year, was 2,261, which gives a mortality rate of 17.39 per 1,000. The age at death varied from 21 to 102 years, the average being 59½. The number of years in practice varied from less than one to seventy-six, the average being thirty. Chief among the causes of death were heart disease, violence, pneumonia, and cerebral hæmorrhage. The number of deaths from violence seems very high-175, including 126 from accidents, 34 from suicide, and 12 from homicide. Of the 126 acidents, 7 were motor casualties. Of the 34 suicides, 20 were due to gunshot wounds, 6 to poison, 3 to cutting instruments, 2 to asphyxiation, and I each to falling, drowning, and strangulation. It is curious that among medical men, who might be presumed to be acquainted with the action of, and to have facility in obtaining, the more painless and easy poisons, shooting should be the favourite means of self-destruction. All the homicides were due to gunshot wounds, and four of these occurred in duels or feuds. The Journal recorded the deaths of several distinguished men during the year, the chief being Nicholas Senn of Chicago, and Roosa and Edebohls of New York.

Expert Evidence.

In a case for damages arising out of a motor smash, heard last week in Dublin, counsel for the defence varied the old plan of abusing the plaintiff's attorney, and instead abused the expert witnesses. Without following him in his criticism in the particular case—criticism, of course, to be regarded merely as advocacy—we confess that the condition as regards expert evidence is one not wholly calculated to support the dignity of the medical profession. It is the custom in every case for damages for injury to produce two or three experts who swear that in their opinion the plaintiff is suffering from injuries of one kind or another of

a certain character. On the other side, equally eminent experts are produced to swear to another view of the alleged injuries. It is really difficult to believe in the bona fides of all the opinions expressed under such circumstances, and, as a matter of fact, evidence is sometimes given so absurd that it can have little effect except on the ignorant juries. On the other hand, many of those who give evidence in these cases are men of acknowledged authority in the profession. Of course, we are not to be taken as in any way reflecting on members of the profession who give expression to their honest opinions in the witnessbox, but there is cause for reflection in what that astute lawyer. Lord Chief Baron Palles, remarked the other day, that he was more influenced by the evidence of medical men in actual attendance on a patient than by that of half a dozen experts.

#### Vermin and Disease.

In the fight against disease no agency which is of service should be neglected. Those that are not against us are for us, and should be enlisted as allies. We confess that we are somewhat inclined to look askance at the Incorporated Society for the Destruction of Vermin, for, while wholly sympathetic with its objects, we do not see quite how their desiderata are to be accomplished. Even the poorest are ashamed of being vermin-laden, and they will strenuously argue that an accuser is mistaken as to his facts, even when the evidence is palpable to the most astigmatic eye. It is not, then, a question of education, such, for instance, as is needed with regard to infectiveness of tuberculosis. Nor can that Mesopotamian panacea, notification, accomplish much, for it is not likely that the legislature would make the notification of bug-bites compulsory, or even permissive. Nor, again, can it be hoped that the law will allow the harbourer of fleas to be marched off by the police for fumigation. In a free country everyone is entitled to enjoy his own coating of dirt so long as he pays his water-rate. Still, the Society for the Destruction of Vermin, so long as it does not draw down too much ridicule from the cavillers at modern manners, may accomplish something in the way of eradicating a fruitful source of disease, and, while we wish them all success, we may say that we fear their path will not be an easy one. It will be difficult to get packed and enthusiastic meetings to support a cause so little appealing to the imagination; leaflets and manifestoes kill no vermin; and there will always be scoffers.

#### PERSONAL.

H.R.H. THE PRINCESS OF WALES has intimated her intention of visiting the Great Northern Central Hospital on Monday, February 22nd, in the afternoon, to open the new ward for children provided through funds collected by the Ladies' Association, of which her Royal Highness is the President.

The Duchess of Albany presided at a meeting of the Executive Committee of the Jubilee Fund of the National Hospital for the Paralysed and Epileptic, Queen Square, Bloomsbury, on January 18th. It was announced that over £11,000 had been collected and promised towards the £50,000 for which the Duchess is appealing, including a donation of £1,000 from Lord Strathcona, the President of the hospital.

- Dr. T. M. Allison has been appointed Honorary Assistant Physician to the Royal Victoria Infirmary, Newcastle-on-Tyne.
- Dr. Phineas Abraham has resigned his post of Surgeon to the Hospital for Diseases of the Skin, Stamford Street, Blackfriars.
- SIR FREDERICK TREVES, Bart., delivered a lecture on "Radium in Surgery" at the London Hospital Medical College, on Tuesday, January 26th.
- Dr. E. F. MACLEOD NEAVE has been elected to the post of Medical Inspector of School Children under Manchester Education Committee.
- LORD DERBY, the President, on January 16th, laid the foundation-stone of a new Liverpool Dental Hospital, which is to be erected on the site near the University and the Royal Infirmary.
- DR. ROBERT JONES has been elected to succeed Dr. T. Claye Shaw as Lecturer on Mental Diseases at St. Bartholomew's Hospital. He has consequently resigned his post at the Westminster Hospital Medical School.

THE Festival Dinner of the Hampstead General Hospital (with which is amalgamated the North-West London Hospital) will be held at the Trocadero Restaurant on February 16th. The chairman is Mr. Samuel Figgis.

AT a meeting of the Royal Statistical Society, held on January 19th, a paper was read, entitled "The Cost, Conditions, and Results of Hospital Relief in London" (Howard Medal Prize Essay), by Mr. Percy E. Braun, B.Sc.

SIR ALFRED JONES, K.C.M.G., as Chairman of the Liverpool School of Tropical Medicine, which he founded, delivered his Inaugural Address to the students on Monday on the subject of "The Practical Importance of the Study of Tropical Medicine."

THE three Morison Lectures of the Royal College of Physicians of Edinburgh are being given in the College Hall by Dr. F. W. Mott, F.R.S., this week, the subject being "Syphilis of the Nervous System in the Light of Modern Research."

DR. CHARLES MERCIER has been awarded the Swiney Prize by the Royal Society of Arts for his work on "Criminal Responsibility." The prize is a cup of the value of £100 and money to the same amount, the award being made jointly by the Royal Society of Arts and the Royal College of Physicians of London.

Dr. J. J. Charles, M.D., D.Sc., F.R.S.E., formerly Professor of Anatomy and Physiology in Cork University College, has presented an engraved die, and a sum of money sufficient to provide an annual gold medal, to be given alternately in the subjects of which Dr. Charles was professor. The governing body have accepted this offer, and ordered that the medal shall be called the "Charles Medal."

THE Council of the Sheffield University on January 18th considered a report, prepared by the Vice-Chancellor, on the application of the increased income which will accrue to the University under the will of the late Dr. Hunter, of Bath, who left the institution £15,000. In accordance with the terms of the late Dr. Hunter's will the name of his father, Joseph Hunter, has to be associated with the fund.

THE German Urological Society will hold its second Congress at Berlin, April 18th to 22nd, 1909. Among the subjects to be discussed are suppurative nontuberculous affections of the kidneys and tumours of the bladder.

## A CLINICAL LECTURE

ON

## THE PERONEAL TYPE OF MUSCULAR ATROPHY. (a).

By ARTHUR WHITING, M.D.Edin., M.R.C.P.Lond.,

Physician to the Prince of Wales's General Hospital, N.; Assistant I hysician to the Mount Vernon Hospital for Consumption and other Diseases of the Chest; Lecturer in, and Dean of, the North-East London Post-Graduate College.

Gentlemen,—We have at various times discussed together different examples of familial disease, such as hæmophilia, angioneurotic ædema, Friedreich's ataxia, and pseudo-hypertrophic paralysis with other myopathies. The subject for our consideration this afternoon is another familial disease; it is also a form of muscular atrophy, but it is not, as we shall see, a myopathy. The muscular atrophies which are not primarily muscular are due, as you know, either to disease of the anterior horn cells of the spinal cord—as anterior poliomyelitis, which may be said to be a massive lesion, and progressive muscular atrophy, which may be said to be due to a cellular lesion—or to disease of the nerve fibres between these cells and the muscle fibres, whether in the anterior roots, the nerve plexuses, the nerve trunks, or the peripheral intra-muscular terminations of the motor nerves. The peroneal type of muscular atrophy, as we shall see, is associated with pathological changes, both in the spinal cord and in the peripheral nerve trunks.

It is called "peroneal" because it seems to start in the muscles below the knee, possibly really in the peronei. It is sometimes said to be a special type of "progressive muscular atrophy," but it is quite unlike that disease; among other things, it begins in the legs, not in the hands; it occurs in early and not adult life, and it is hereditary.

The three patients who have come to hospital this afternoon for the purpose of this demonstration are a middle-aged man and his two daughters, who have been under Dr. J. R. Halliday's observation and my own for several years. The man's mother and brother had the disease, as also had his maternal grandfather. I do not propose to give you now all the clinical details of these cases; those Dr. Halliday and I hope to publish together shortly, but the following is an abstract of their case-records:—

The first patient, the father of the other two, a cardboard cutter by occupation, is forty-four years of age, has suffered from paralysis followed by clubbing of his feet since he was eight, and from paralysis followed by clawing of the hands since he was thirty-two years of age. The hereditary history is as follows:—His mother, whose family consisted of the patient and his brother, developed clubbing of the feet at the age of seventeen; her father had deformity of the feet; of her two sons, the younger brother of the patient developed clubbing of the feet at seventeen, and clawing of the hands between the twentieth and twenty-fifth years. Patient's younger daughter showed a tendency to club-foot at ten, and weakness of the hands at eleven, and an elder daughter is now obviously developing the condition. He was healthy up to the age of eight, when he had measles, and shortly afterwards the condition from which he is now suffering began to develop. He has always been temperate, and has never had any venereal disease. A few

months after recovering from the attack of measles. he began to walk on the outer edge of his feet, and some seven years later he underwent an orthopædic operation for club feet. The condition remained stationary until thirty-two, when the weakness of his legs increased, his hands began to be weak and he was unable to feel things in the dark so well as before; during the next few years he developed some ataxy in walking and standing, so that he fell into the basin when he washed his face; he had shooting pains in the legs at intervals, girdle sensation and perfection when the washed her bett for tion, and perforating ulcer developed on both feet. It may be said here that his brother also suffered from perforating ulcer of the feet. His present. condition is as follows:-He is a pale, obese man with a rather expressionless face; there is double club-foot with claw toe; inability to abduct or ad-duct the feet or extend the toes; wasting of the muscles below the knees, especially of the peroneal group, with modified reaction of degeneration in the wasted muscles; absence of the knee-jerks; coldness with pigmentation and glossiness of the skin of the legs, and sock anæsthesia to touch, pain, and temperature. There is double claw hand, with marked wasting of the thenar, hypothenar, and interosseous muscles, and slight wasting of those of the forearms with similar electrical changes. There is glove anæsthesia to all forms, but no ulnar anæsthesia. There is some ataxy of both legs and arms, Romberg's sign, small un-equal pupils showing the Argyll-Robertson phenomenon, and a persistent open perforating ulcer on the right foot, and the scar of a healed one on the left. He has had no sphincter trouble, and the optic discs are healthy. There are fibrillary tremors in the intrinsic muscles of both hands, and lateral curvature of the spine, with convexity to the right. The body organs are healthy. Careful search revealed no evidence of any thickening of the peripheral nerves.

Case 2.—The second case is that of the younger daughter of the patient just described. She is sixteen years of age. She had whooping-cough when three years old, but remained apparently healthy until the age of ten, living an ordinary active life of childhood. Shortly after she was ten she began to walk on the sides of her feet, and about a year later weakness of her hands was noticed.

Her state, on examination, was that the muscles of the legs below the knees were wasted; when lying down or sitting with the legs dangling she showed double drop-foot, and there was slight talipes varus, with some pes cavus. She could not dorsiflex the right foot at all, and the left foot only very feebly, and she could not stand on tip-toe. The knee-jerks could not be obtained even with any method of reinforcement. There was some anæsthesia of the feet, especially about the soles. There was no obvious atrophy in the upper limbs, but that the weakness was considerable and progressing was shown by the fact that whereas a few months before (I am now quoting Dr. Halliday's notes) she was able to open the spring of a neck fur with-

<sup>(</sup>a) Delivered at the North-East London Post-Graduate College (Prince of Wales's General Hospital, N.), on November 26th, 1908.

her hand, she was now unable to do so, and used her teeth for the purpose. There was lateral curvature of the spine with the convexity to the right. The electrical examination was difficult owing to the patient's nervous state, but the general result was that there was a marked diminution of faradic excitability. There was no ataxy, and the pupils gave normal reactions.

Since these notes were taken the girl has been increasing rapidly in height and weight, her legs now drag in walking, the big toes turn up, she wears away the soles of her boots on the inner side before the rest, and her hands have become splaw-like, so that she has to use her whole hand (or the fingers alone) when she takes off her boots

or other clothing.

Case 3.—I do not intend to trouble you much with details of the case of the elder sister. I shall merely say that she is apparently just beginning to follow the course of her younger sister. There is weakness and some wasting of the muscles on the outer side of the legs below the knees, and the knee-jerks cannot be obtained even with reinforcement. The electrical reactions have not been taken mainly because the patient has a rooted objection to that method of examination.

Neither do I intend to trouble you with details of the earlier cases in the family, merely saying that the only brother of Case 1, the uncle of Cases 2 and 3, developed clubbing of the feet at sixteen, clawing of the hands about twenty-two, and perforating ulcers in both feet about the same time, for which the right foot was amoutated when he

was twenty-three.

The mother of the first patient developed clubbing of the feet at seventeen; she married at thirty-five and had only two children—the two sons already referred to. She could play the piano up to shortly before her death, which occurred at fifty from heart disease, so her hands were, presumably, unaffected.

Her father, the great-grandfather of the two younger patients here this afternoon, suffered from some deformity of both feet, which may probably be safely assumed to have been the family clubbing.

This family group of cases affords instances of the peroneal type of muscular atrophy, the more exact knowledge of which symptom-complex dates from 1886, when Dr. Howard Tooth in this country, and MM. Charcot and Marie in France, clearly differentiated it from progressive muscular atrophy of myelopathic origin on the one hand, and from primary myopathies on the other. But about ten years before that, Leyden and others had pointed out that those cases of progressive atrophy which did not begin in the hands as in the Aran-Duchenne type, but in the feet were often here-ditary.

The atrophy and weakness usually manifest themselves in childhood, and, it is alleged, first of all in the peronei, but it is a question whether the onset is not, often, at least, first in the intrinsic muscles of the feet, a position in which the effects of weakness would not soon be obvious. Then the atrophy attacks the tibialis anticus, the long flexors of the digits, and, later, the calf muscles. There develops a talipes varus, and usually claw toe as well. Next the thigh muscles are affected, particularly the lower thigh muscles, and of these the vastus internus especially. Next, after a greatly varying interval, as our cases show, the intrinsic muscles of the hands are affected, giving claw hands; indeed, it may be said that this is about the only disease in which claw hand does appear in early life. Later still, the forearms and upper

arms are affected, and the wasting may indeed become general. The knee-jerks are absent in the developed case; there is usually patchy anæsthesia of the hands and feet and legs, but there is, as a

rule, no sphincter trouble.

The electrical reaction may be said, I think, to be characteristic. As a general statement, it may be said that there is reaction of degeneration—somewhat modified, perhaps—in the wasted muscles, but the remarkable thing is that there is greatly diminished excitability to faradism, even in the muscles that are not wasted or obviously weak, and at the same time the sensibility to faradic stimulation of the skin is greatly reduced. To galvanism a contraction was obtained in my own muscle with 2.75 milliampères. No contraction in the biceps of the patient (not specially atrophied), and only a very doubtful one in the interossei was obtained with a current of 20 milliampères. I may say that there was no appreciable atrophy of this man's facial muscles, but his face was distinctly expressionless.

These cases, then, correspond with the describer type in their hereditary tendency, in the onset it early life after an acute specific fever (in the father of the two girls, as has often been the case in other patients, after measles), in the double club-foot and double claw hand, with anæsthesia and characteristic electrical phenomena, both in the muscles that were obviously wasted and in those

that were not.

The unusual features of the first case are those that suggest tabes dorsalis, to wit, together with the absent knee-jerks and patchy anæsthesia, the ataxy, the shooting pains, the Argyll-Robertson pupil, and the perforating ulcers of the feet. But this case is by no means unique in its manifestations of tabetic signs. It may, however, be well to remark that, after most careful examination and consideration, the previous occurrence of specific disease was excluded from this patient. Without troubling you with names of authorities or precise references, I may say that by several observers lightning pains have been recorded in similar cases, also by one, at least, the Argyll-Robertson pupil, in others optic atrophy, in some myosis, and in a few difficulties with urination, and in even one-I had thought Dr. Halliday's were unique-perforating ulcer.

To summarise the pathological findings of the more recent investigations, several have found degeneration of peripheral nerves, muscles, and posterior columns of the cord; some have found lesions both of the posterior horns and the anterior horns, and a few have observed a hypertrophy of the interstitial substance of the nerves. I may remind you that muscular atrophy is by no means unknown in unequivocal cases of tabes dorsalis.

In reference to the question of sex-frequency, it is usually said that males are more frequently affected than females as five to one, but in the present family that does not appear to be the case; indeed, the heredity seems to follow the rule in certain other nervous disorders of transmission from the mother to the son, and the father to the

daughter.

In reference to ætiology, it is clear that there is an inherited vulnerability, to say the least, of nearly the whole of the lower nervous system, and, indeed, possibly also of the higher, as an erratic, bizarre, excitable psychology is held by some to be characteristic of the disease. In this respect it seems very closely to resemble Friedriech's hereditary ataxia.

In addition to this predisposing cause, there is clear evidence that in many cases there is also an exciting cause, usually in the form of some acute

specific fever, particularly, as the case-records seem to suggest, measles; but other toxic agents, as alcohol and lead, have been held to participate, and even conditions of muscular and mental stress have seemed to have had a share in the development of

Up to the present, effective treatment may be summed up in almost a word, namely, well-directed tenotomies; any other is of but little, if any, avail.

Note.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor A. Dietrich, M.D., Prosector at the Krankenhaus, Westend, Charlottenburg Berlin. Subject: "Simultaneous Existence of Congenital and Acquired Disease of the Heart."

#### ORIGINAL PAPERS.

#### CASE OF INCONTINENCE OF URINE ASSOCIATED WITH EPISPADIAS.

By R. P. ROWLANDS, M.S., F.R.C.S., Assistant Surgeon to Guy's Hospital.

A BOY, æt. 6, was sent to me early in June, 1908, by Dr. B. A. Richmond, of Bermondsey, for incontinence of urine associated with epispadias. He was able to retain the urine fairly well while lving down at night, but directly he either stood or sat up it ran away. Throughout the day the water dripped into the clothes, keeping the trousers constantly wet and rotting them in a short time. Dr. Richmond wrote that "complaints were made at school that the boy was undesirable, because his clothes smelt so strongly. I hope that you will be able to recommend something to relieve a very distressing condition. The question is, can any plastic operation be done?'

In other respects the boy was well developed, except that the right testicle was retained in the inguinal region, and that the symphysis pubis was depressed and thin. The penis was so extremely small, that only a little bud presented below the arched lower border of the pubic skin. The epispadias was nearly complete, but the cleft did not extend quite into the bladder, the posterior inch of the urethra being roofed over with mucous membrane only.

Diagnosis.—It was obvious that the bladder was of fair size, because it was capable of holding all the urine secreted during the night, if the body lay horizontal. The complete incontinence in the vertical position proved that there could be no sphincteric control. Gravity, atmospheric pressure and the apposition of the mucous walls of the urethra were usually sufficient to prevent leakage while the trunk remained flat and the muscles at rest. It was concluded, therefore, that although the cleft did not extend into the bladder, the sphincter had failed to meet in front of the urethra, and the neck of the bladder. It was hoped that some of the muscle fibres existed, but that they were powerless, because they had not been able to complete the circle that is necessary for control.

Treatment.—In considering the treatment of this boy it was clear that it would be almost impossible to fit him with a urinal that would both keep him dry and make him "desirable" at school. The sickening odour of stale urine would still make him an unpleasant companion, and the object of derision, for even the best cleaned urinal smells. It seemed to me that it was worth while for this boy to run a considerable risk in order to be rid of his incontinence, and to be saved from a pestilent urinal as a permanent necessity. I therefore recommended an operation, although the chances of complete success did not seem to be good. If the operation should fail a urinal could be used, or the urine could be diverted into the rectum in one way or another. In a few cases of epispadias with extension of the cleft through the neck of the bladder, Trendelenburg had been able to construct a moderate sphincter by carefully suturing the freshened and liberated edges of the cleft. This has only been possible after mobilising the sacro-iliac synchondrosis so that the pubic bones could be brought together and wired.

Operation.—At the end of July, 1908, a lateral flap with its convexity to the right was raised from the thin cartilaginous symphysis, which was then divided vertically. The neck of the bladder and the short urethra were carefully separated from the pubic bones, which were retracted, leaving a gap of nearly an inch and a half between them. The subperitoneal fat was drawn up and the lower part of the bladder and the urethra were freely and carefully separated from their lateral attachments by blunt dissection. When the bleeding had been checked, no muscular or prostatic tissue could be seen in front of the neck of the bladder or urethra, whose anterior wall consisted of mucous membrane only. This was carefully saved. The lowest The lowest part of the anterior wall of the bladder was alsovery thin and almost devoid of muscular fibres.

By means of Lembert sutures of fine catgut the muscular and fibrous tissues upon the sides of the urethra and the lower part of the bladder were brought together in front of the carefully preserved mucous membrane, which was thus invaginated. In this manner the passage was so narrowed that it firmly gripped a No. 4 selfretaining rubber catheter, which had been inserted. The lateral separation had been free enough toprevent undue tension upon the sutures. The edges of the pubic bodies were freshened and fixed in apposition by means of wire. wound was accurately closed. At first all the urine drained away through the catheter, but this became blocked and had to be changed after the fourth day. When the instrument was finally removed there was incomplete control of the urine, both day and night, but gradually the incontinence diminished. Firm union has occurred between the pubic bones, and the gait is perfectly natural. No attempt was made to correct the epispadias, this being deferred until the result of the operation for incontinence is certain.

Six months later Dr. Richmond kindly writes: "You will be glad to know that the boy you operated on is very much better. He has much more control and can attend school without any inconvenience."

Remarks.—This case seems to be worth recording for several reasons. As far as I know this method of treating the incontinence sometimes associated with epispadias by inversion is original. All the work is external to the mucous membrane which is not injured. In former operations the edges have been pared and brought together. Professor Trendelenburg has reported several more or less successful cases of partial ectopia, which he had treated in this manner

after mobilising the sacro-iliac synchondrosis. Although the rather delicate operation was based upon anatomical and pathological information, I did not venture to expect it to be so successful as it has been. The amount of muscular tissue to be found at the neck of the bladder was uncertain, so that one wondered if it would be possible to bring it round the urethra in front without unduly narrowing the passage. The degree of control that this measure would ensure was also a matter that could not be decided beforehand, for although the nervous supply is postero-lateral, and therefore not likely to be seriously affected, I could not be certain if it would be adequate, even if the muscular approximation remained permanent. The result is, therefore, instructive, and gives rise to considerable speculation.

I was pleasantly surprised to find that the pubic bodies could be so easily retracted in a boy, æt. 6, without the need of interfering with the sacro-iliac synchondroses. A good view of the neck of the bladder was obtained when the free venous bleeding had been checked by pressure for a few minutes. I took care to preserve this mucous membrane intact, not even passing any sutures through it, so that urine might not leak into the cellular tissues a few days after the operation, when the tissues softened or the catgut sutures perchance gave way. Extensive lateral bites were secured so that the sutures might not tear through, and for greater security interrupted sutures were used. The infolding was carried well up beyond the neck of the bladder, and also into the prostatic and membranous portions of the urethra.

The muscular tissues above the neck of the bladder were brought down to the neck by means of sutures passed obliquely from each side. In this manner the circular fibres of Thomson were brought round the neck of the bladder. These lower circular fibres are supposed to be endowed with the chief sphincteric control. In enlargement of the prostate, the vesical projections pass up within a hypertrophied ring of these fibres, which are carefully preserved during the enucleation.

It is probable, however, that the muscular

prostate of the young and the compressor urethræ take their part in controlling the urine, and for this and other reasons it is wise to approximate these parts in front of the urethra. In a child this is not easy, for the cleft prostate is minute and the periurethral tissue is scanty, under the circumstances of the operation.

My best thanks are due to Dr. B. Wallis, then house surgeon, and to my dressers for their help during the operation, and for their unremitting care of the patient during his stay at Guy's Hospital.

### A STUDY OF

# TEN CASES OF OPERATION FOR PERFORATED GASTRIC ULCER. (a)

By CHARLES MORTON, F.R.C.S.,

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I FIND, on looking up my records (a) that I have operated on ten cases of perforated gastric ulcer, with seven recoveries, and I propose in this paper to give a brief abstract of them, and to point out the lessons I have learnt from them. As we might expect, the

(a) "Bristol Medico-Chirurgical Journal," September, 1908.

chance of recovery depends very largely on two things one, the time which elapses between perforation and operation, and, the other, the extent of extravasation of stomach contents. The following table by Robson and Moynihan (a) shows the relation of the result to time of operation:-

	Total			
	Cuses.	Recovered.	Died.	Mortality.
Operation under 12 hours	49	35	14	28.5
., from 12-24 hours	33	12	21	63.6
" from 24—36 bours	16	2	14	87.5
" from 36—48 hours	2	0	2	100.0
over 48 hours	33	16	18	51.5

But it seems uncertain whether these statistics are taken from consecutive series of cases. If not, they will almost certainly fail to give the real mortality, for single fatal cases do not as a rule get published, Paterson found that in a series of consecutive cases operated on within twelve hours the mortality was 47 per cent., within twelve to twenty-four hours 50 per cent., and from twenty-four to forty-eight hours 83 per The difference between his first and second periods of twenty-four hours is therefore very marked. All my three fatal cases had general peritonitis. In one thirty-nine hours had elapsed between perforation and operation, in another forty-nine, and in the third three days; but one of the successful cases (Case 3) was not operated on for thirty-nine hours after perforation, but in this case the extravasation was slight, and the peritonitis localised. In two of these three cases the patient was in a very collapsed state before operation, and the third died nearly three months after operation, and some time after a subphrenic abscess had been drained. The mortality after operation for perforated gastric ulcer has been considerably reduced in the last few years, owing perhaps to earlier diagnosis. Mr. Crisp English (b) found that only 52 per cent. recovered out of forty-two consecutive cases at St. George's Hospital up to 1903; and Mr. Sargent (c) gives 58 per cent. recoveries in forty-nine cases at St. Thomas's Hospital up to 1904. Mr. Moynihan's results, published in 1906, (d) are much better—66.6 per cent. recoveries in twenty-seven cases; and Mr. Crisp English and Mr. Turner together, at St. George's Hospital, had nine cases with only one death. In my ten cases the recoveries were 70 per cent.

Diagnosis.—The diagnosis of several of my cases was not difficult, but it is worth while calling attention to what has been called the "latent period." The symptoms of onset may be most acute, and then in a few hours there may be so little pain that you are put off your first diagnosis. In Case 4 the diagnosis was much less certain when we saw the patient just before operating than it seemed earlier in the day, but fortunately we decided to operate. In other cases in this series it will be noted that the severe pain had passed away before I saw the patient. But in the latent period the rigidity will usually persist, and also a certain amount of tenderness, though the frequency of the pulse may lessen. In two of my cases appendicitis was diagnosed (Cases 5 and 7). In Case 5 the tenderness and fulness were most marked in the appendix region, and in Case 7 the history was that the pain had been there. This is not at all an uncommon mistake, especially with perforating duodenal ulcers-indeed, with the latter it is quite frequent. Extravasated fluid runs down into the right iliac region in these cases, and peritonitis is marked there. The mistake matters really very little, provided we operate, for we can easily extend our incision in the rectus up to the stomach region; but the fact that in nineteen out of fifty-one cases of perforated duodenal ulcer collected by Moynihan a diagnosis of appendicitis was made, is an additional argument in favour of early operation in all cases diagnosed as acute appendicitis with severe symptoms at the onset, at any rate in adults. It seems to me that rigidity of the abdominal wall is one of the most important signs of perforated gastric ulcer,

<sup>(</sup>a) "Diseases of the Stomach," 1901, p. 161.
(b) "Medico-Chirurgical Transactions," 1904, 1xxxvii. 27.
(c) "St. Thomas's Hospital Reports," 1904, xxxiii. 477.
(d) "Medico-Chirurgical Transactions," 1906, 1xxxix. 47L

though when general peritonitis was present in Case 8 there was neither rigidity nor tenderness, but the

patient was in a very collapsed condition.

In connection with the diagnosis of perforated gastric ulcer, it may be well to call attention to a source of error pointed out by Moynihan. (a) He says he knows of three cases in which negative exploration for perforated gastric ulcer was performed in women at the commencement of menstruation. Sharp abdominal pain, with vomiting, distension, and collapse were the symptoms and signs present. In one of his own cases (in which he did not explore) the absence of any rigidity and tenderness in the abdomen negatived perforation. There may be a history of previous similar attacks at menstrual times.

We must not fail to diagnose a case as one of perforated gastric ulcer because shortly after the onset of symptoms shock is not present. In one of my cases (Case 9) I saw the patient one hour after perforation; his pulse was 112, not very bad, nor did his general condition suggest collapse. Neither was Case , seen a few hours after perforation, suffering from collapse. Moynihan says (b) that within the first two hours, though the pain is very severe, there is no rigidity or collapse, or any marked rise in pulse rate. However, in one case I saw an hour after perforation the whole abdomen was very rigid, and I believe collapse may be very marked. Mr. Pearce Gould ( $\epsilon$ ) refers to a case of sudden death from the shock of per-

forated gastric ulcer.

Treatment.—The method adopted for cleansing the peritoneal cavity differed in the successful cases-in some I sponged, and in others I flushed. If the extravasation and effusion of fluid and lymph is localised, it seems to me that it is unwise to risk further dissemination by flushing. In cases in which extravasa-tion or inflammatory effusion is widespread, especially if stomach contents are widely diffused, perhaps flushing is the more satisfactory method, as there is less manipulation, and therefore less tendency to shock, and I should expect the cleansing to be rather more thorough than with sponging, if plenty of saline solution is used; (d) but I have learnt from my experi-ence of the treatment of diffuse peritonitis from appendix disease how well most cases do after sponging, and unless there were evidence of very wide—almost general-diffusion of infective material, there is a risk of infecting fresh areas in flushing. Paterson is opposed to irrigation, because he has observed when giving the anæsthetic that if the patient was not very deeply under, when flushing was used there was weakening and quickening of the pulse. But he does not tell us if he has observed the effect of sponging on the pulse. He only recommends sponging of the space "above and behind the liver." He suggests sucking out the fluid from the pelvis. He avoids sponging, because he thinks it will interfere with peristalsis after operation, and he seems to depend more on the action of purgatives after operation to cleanse the peritoneal cavity than on flushing or sponging at the time of operation. I should rather still be inclined myself to act on advice given by Pearce Gould more than ten years ago-not only to operate early, but to spare no pains in thoroughly cleansing the peritoneal cavity.

If the intestines have to be turned out of the abdomen in order to get room to flush, then I think there would be greater shock with flushing than with sponging; but then sponging without evisceration would probably not be effectual in cleansing the peri-

toreum because of the tight packing of the intestines.

In all the eight successful cases of Crisp English and Turner (e) irrigation was employed, and suprapubic and loin counter-openings made before the irrigation was started, so that free exit for the fluid was provided. In nearly all the cases the supra-pubic openings disclosed a pelvic collection of "peritoneal fluid and stomach contents." This shows how im-

portant it is in all cases of perforated gastric ulcer to examine the pelvis, if not by a separate opening, at any rate by inserting into it a sponge on a holder. If fluid is found, then I should certainly make a supra-pubic opening for cleansing and drainage, but I should not do so in every case, nor make counter-openings in the loins either. The right kidney pouch and the left loin can both be drained by long split tubes with gauze wicks from the anterior ab-dominal wound, but in some cases of very extensive infection of one or other loin no doubt a counter opening there would be advisable. In every case, even though the extravasation or the peritonitis was quite localised around the perforation, I should certainly drain, and of all drains the split drainage tube with gauze wick seems to me the best. Barker (a) has recorded twelve consecutive cases of perforated gastric ulcer treated by sponging, with five recoveries. If we compare the results with Crisp English and Turner's after irrigation, we must remember that so much depends not only on the period which elapsed between the perforation and the operation, but on the extent of extravasation of stomach contents, that we can hardly conclude that irrigation is the best method to

employ in all cases.

In all my cases but one I have been able to close the perforation by suturing, though in some it was very difficult to get the stitches to hold in the indurated friable tissue around the perforation, and in several the suturing was supplemented by an omental graft. In Case 4 I could not suture, the induration around the perforation was so great, but omental grafting alone answered well. It is a mistake to suppose that free gas is always present in perforated gastric ulcer. It was suggested some years ago that all that was necessary to settle the diagnosis of doubtful cases of perforated gastric ulcer was to make a very small incision and see if free gas was present. If this test had been relied on, many perforations would have been missed. You must examine every part of the stomach. If you find no perforation anteriorly, you must divide the gastro-colic omentum, and examine the posterior surface of the stomach, though perforations here are rare. All my ten cases were anterior perforations. You are often led to the perforation by increased redness and lymph deposit perforation by increased redness and lymph deposit on the wall of the stomach, and by pressure on it gas and stomach contents may be forced out. It has been suggested that air may be pumped through the perfcration through an œsophageal tube passed from the mouth, but pressure on the stomach ought to be sufficient to cause the exit of gas or fluid at the perforation. Because free gas is often not present in the peritoneal cavity in these cases, there may be no alteration in the liver dulness. I should say there alteration in the liver dulness. I should say there rarely is obliteration of it, even if free gas is present. In a distended abdomen it may be obliterated from distension of the intestines, but in a flat abdomen I have seen it absent and no free gas present, so that I do not regard the presence or absence of liver dulness as a very reliable guide in these cases. Barker (b) has come to much the same conclusion from a study of his twelve cases. He found liver dulness present with abundant free gas, and absent without any free

I have never felt inclined to adopt the suggestion made of late years by some surgeons, to do gastro-jejunostomy as well as close the perforation. Patients with perforated gastric ulcer do not seem to me suitable cases for any more operative interference than is absolutely necessary to save life, even in cases of early operation, and they do very well with suture alone if peritonitis has not already set in. Nor, for the same reason, should I excise a perforated gastric ulcer, though several surgeons have done this, but not with much success. (c)

Mayo Robson says (d) that if the patient's condition will permit of it, the question as to the performance of gastro-jejunostomy should be considered, because other ulcers may be present and will be cured, and if on the point of perforating, perforation will be pre-

<sup>(</sup>a) "Abdominal Operations," 1908, p 144.
(b) Bri: M. J., 1906, ii, 1397.
(c) Ibid., 1894, ii, 890.
(d) I see this line of practice is recommended by Mayo Robson.
Brst. M. J., 1908, ii, 1347.
(e) Loc. cit.

<sup>&</sup>quot;Transactions of the Clinical Society of London," 1900, xxxiii. 39.

<sup>(</sup>c) Paterson loc. clt. (d) Bril. M. J., 1906, ii. 1347.

vented, the sutured ulcer will heal better, there will be less risk of hæmatemesis, saline purgatives can be given, and will assist in the absorption of peritoneal fluids, and early mouth feeding can be resorted to. Paterson (a) recommends it for much the same reasons, and Moynihan (b) seems inclined to recommend it in early operations, to aid the healing of the sutured ulcer, and to cure others which he says are usually present. As he points out, if in closing the perforation we have to seriously narrow the pyloric part of the stomach, it may be absolutely necessary, but the other reasons seem to me hardly urgent enough to demand it, for even though 'he operation is done early and the patient may bear the earlier stage of the operation well, yet we must remember that there has been very severe pain, and the less manipulation of the abdominal viscera the better.

It may be necessary to do gastro-jejunostomy later for the condition of the stomach resulting from the ulcer, or if the ulcer will not heal with prolonged medical treatment. In one of my cases (Case 4) I had to do the operation for "hour-glass" stomach, due to contraction of a chronic ulcer six months after the closure of the perforation. But because gastro-jejunostomy may ultimately be necessary, I should not do it at the time of closure of the perforation. Some surgeons would, however, regard the possibility of later trouble as an argument for the performance of gastro-jejunostomy at the time of closure of the perforation.

CASE 1.—Mrs. M., 40, March, 1908. Children's and Women's Hospital. History of pain and vomiting after food for some months. Pain very severe below left costal margin, extending up chest into left arm. Came on three hours after dinner. Four hours later seen with Dr. Osmond Bodman. Not then in much pain, but could not breathe deeply. Pulse under 100. Abdomen tender and rigid almost all over, but especially just below left costal margin. Three and a-half hours later tenderness and rigidity were much less, but still marked below the left costal margin. She seemed easy, and could breathe more deeply. Operation eight hours after perforation. Perforation in section eight hours after perforation. Perforation in arterior wall, near esophageal orifice, with free escape of gastric fluid, but no free gas. Brown fluid in pelvis and lymph in both renal regions, as well as in region of stomach. Perforation sutured. Infected parts thoroughly sponged. Supra-pubic drainage open-ing, and drainage tube into right loin and splenic region from original wound. No shock. She made a good recovery. Feeding by nutrients only for 14 days, and then by liquid only for some time.

CASE 2.—Miss B., 25, January, 1907. General Hos-

pital. At onset very severe epigastric pain, four hours after a light meal, and continued for hours until opium given. I saw her with Dr. Cook thirty-five hours after perforation. There was then very little pain, and there had been no vomiting save a little retching at five years ago, and a little epigastric pain a few days before. Considerable general tympanitic distension was present, with tenderness and rigidity under the left costal margin. Pulse, 140; temperature, 102°. Operation 37½ hours after perforation. Perforation on anterior surface, just below lesser curve, and 3 in. from pylorus. Sutured, and omental graft used. Lymph and serous fluid in upper abdomen, including right kidney pouch, none in lower. Sponged. No counter openings, but many drainage tubes with wicks. Moderate shock. Fed by nutrients only for some time, then liquids only. Twenty-four days after operation began to expectorate pus, and serous fluid found at left base. Both conditions cleared up. Discharged quite well two months after operation.

CASE 3.—Rose G., 20, November, 1906. General Hospital. Epigastric pain after food 14 days. Onset 6.30 a.m. before any food taken, and very severe pain in epigastrium. I saw her thirty-six hours after perfora-tion (had taken milk in meantime), and then she was not in pain. Moderate general distension, with slight general tenderness, but marked tenderness and rigidity over upper left rectus. Condition essentially the same three hours later. Pulse 120. Operation thirty-nine hours

after perforation. Upper left rectus remained rigid even under anæsthetic. Localised peritonitis about stomach. Perforation in lesser curve near œsophagus. Sutured. Pulse 140, but not feeble at end. Fed by nutrients only for 14 days. Discharged well about six weeks after operation.

Case 4.—Miss R., 45, April, 1905. Gastric pain and vomiting for one month, and same symptoms with hæmatemesis some years before. At onset very severe abdominal pain, so that she could not move, and felt 'as if something had broken in her side." Dr. Michell Clarke saw her seven and a half hours after perforation, and I saw her with him shortly after. Pain was then severe in epigastrium and left loin anteriorly, and she could not breathe deeply enough to speak plainly (as in Case 1). Pulse 120, not feeble. No vomiting. Twelve hours after perforation she was quite free from pain (no morphine) and pulse was less rapid, but the upper abdomen, especially the upper part of the left rectus, was very rigid and very tender. Operation thirteen and a half hours after perforation. Perforation in lesser curve. There was very great induration around, so that it was not possible to suture. The perforation was closed by an omental graft. There was only localised extravasation of stomach contents. Sponging and free drainage. No serious shock.

Sponging and free drainage. No serious shock.

CASE 5.—K. M. (female), 19. March, 1905. General Hospital. Suffered from epigastric pain and nausea for some time. At onset very severe pain, "doubling her up," and vomiting. Pain and vomiting continued. Seen by me about forty-six hours after perforation. Pulse 140, feeble; temperature 100.6°. Tense general abdominal distension and tenderness, most in right lower abdomen, but no rigidity. The greatest tenderlower abdomen, but no rigidity. The greatest tenderness and fulness being in the right lower abdomen, I opened the abdomen here forty-nine hours after peropened the abdomen here forty-nine nours after perforation, thinking it might be appendix trouble. I found a diffuse purulent peritonitis. Perforation was near the pylorus, and covered by lymph. Lymph peeled off, and perforation sutured. Sponged and counter opening for drainage made above pubes. Multiple drains. By fourth day much better. Pulse Number of the property of the nearly three months after operation. At post-mortem, perforation sutured at operation found as a scar, and another ulcer had perforated, but was closed by adhesions. An abscess was found in the liver, and a considerable quantity of serous fluid with flakes of lymph in the pelvis, and a little pus was shut up amongst adherent coils of intestine.

CASE 6.—Mabel R., 14, November, 1904. Children's and Women's Hospital. Epigastric pain and vomiting for a week. Then severe sharp pains, which persisted, but she walked from City up to hospital the next morning, after a light breakfast, when the pain got more intense, and she became collapsed. It is not easy in this case from the symptoms to fix the time of perforation, but from the condition within the abdomen I should say it took place that morning, and that the other symptoms were due to peritonitis at the base of the ulcer. I saw her about two hours after the most intense pain came on. The abdomen was board-like all over, and tender below the left costal margin, and in left iliac fossa, and hardly at all dis-tended. The severe pain had gone, and she only had pain on breathing deeply or moving. Operation four hours later. Then temperature 102°. Perforation on anterior surface near pylorus was found and sutured. clear fluid in left iliac fossa and pelvis. Irrigated with counter-opening for drainage above pubes. Lymph on stomach, but no general peritonitis. No shock. Discharged well a month after operation.

No complications.

CASE 7.—E. C. (female), 25, May, 1908. At onset severe abdominal pain. Seen with Dr. Eberle and Dr. Walker Dunbar thirty-six hours after perforation. Another severe attack of pain ten and a half hours before I saw her. Pain had been on right side of

abdomen, and ruptured appendix abscess was diagnosed. Temperature had been 1020 earlier in the day. Pulse too feeble to count, and she seemed too bad to have much chance of recovery, but her relations wished to give her any slight chance which operation might give, if she died under it. Abdomen was much distended, rigid, and generally tender. Operation thirty-nine hours after perforation. Perforation near pylorus on anterior surface, with general peritonitis.

Flushed. Died at end of operation.

Case 8.—Male, 18, May, 1903. General Hospital.

Onset with severe pain in left abdomen. Supposed to be suffering from pleurisy before admission. Friction heard, probably peritoneal. Admitted three days after perforation, and when seen by me a few hours after admission pulse was very feeble (130) and extremities chilly, though a warm evening. Abdomen distended with shifting dulness, but no tenderness or Immediate operation. Perfor Perforation on anterior surface near pylorus. General peritonitis. Flushed. Died soon after.

CASE 9.—Mr. V., 45, July, 1903. General Hospital. Had been medical out-patient for gastric symptoms before onset of severe general abdominal pain and vomiting, when lifting a heavy weight. Seen an hour after. Then in great pain all over abdomen, and abdomen very rigid and tender all over. Loud friction heard over lower part of left chest below nipple. Operation five hours after perforation. Perforation on anterior surface close to pylorus. Sutured. Fluid widely extravasated. Flushed. No shock. Fed by nutrients only for ten days, and then only liquids for a time. Discharged well about two months after a time. Discharged well about two months at operation. Some bronchitis the only complication.

CASE 10,-E. M. W. (female), 26, October, 1901. General Hospital. For three months subject to epigastric pain. At onset severe pain below left costal margin, ten and a half hours before I saw her, when laughing, and two hours after taking a teacup of arrowroot. Had had two previous severe attacks of pain, two days and four days earlier. When I saw her she was not in any pain, but had taken a pill to relieve the pain (prescribed by her doctor) four nours earlier. Abdomen was rigid all over, and very tender below left costal margin. Operation eleven hours after perforation. Perforation near œsophageal orifice on anterior surface, and very difficult to reach. Only localised extravasation. Sponging.

### REMARKS UPON

### SOME GONORRHŒAL DISEASES OF THE EYE. (a)

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THAT the professional conception of gonorrhœa is different from what it was not so very many years ago, is a self-evident proposition that will be disputed by no well-informed medical man. We now recognise that gonorrhœa is not always a harmless local order, perhaps the worst result of which might be a strictured urethra, as was generally thought twenty-five or thirty years ago.

There have been two main changes in medical

opinion:—(1) That systemic infection by the gonococcus is commoner than was once supposed. These infections appear to take place only in cases where the posterior urethra and contiguous structures are involved. Modern researches go to show that the gonococcus itself is responsible for the infection, and it may now be fairly claimed that the  $r\delta lc$  of so-called "mixed infections" and of gonotoxin is becoming less and less important as a cause of the metastases. These infections include arthritis ("gonorrhœal tism"), endocarditis, pleuritis, peritonitis, iridocyclitis, teno-synovitis, and, lastly, septicæmia and pyæmia. Every single one of the conditions named

(a) Based upon a Clinical Demonstration given at the Polyclinic, London, on May 8th, 1908.

implies infection of the blood with gonococci, and, in point of fact, the organisms have been often found in that fluid. It is difficult to say why one individual should escape general infection and another develop Traumatism, in some cases, at all events, takes a share in the process. Moreover, it is possible that certain strains of gonococci are more virulent than In this connection Ahmann's experiment is suggestive. Ahmann (1) inoculated the urethra of a healthy subject with gonococci from the blood of a man suffering from systemic gonorrhoral infection. The result was that the first subject developed not only urethritis, but septicæmia as well. (2) That the disease may persist as regards infectivity for an almost indefinite period. This is the theory of "latent gonorrhœa" placed prominently before the profesgoinfine placed prominently before the places sion more than thirty years ago by Emil Noeggerath. Noeggerath (2) maintained that 90 per cent. of the cases of gonorrhœa remained uncured, and that, of the women who married men once affected with gonorrhœa, few remained healthy, the rest suffering from various induced ailments, such as endometritis or metritis, pyosalpinx, salpingitis, evaritis, or perimetritis. The disease might lurk indefinitely in the follicles of the male urethra, and cause infection when transplanted upon a suitable soil, such as the mucous membrane of the vagina or eye. Noeggerath's views were received with incredulity at the time he stated them, but I am under the impression that they are nowadays generally accepted, although, perhaps, in a somewhat modified form. That latent gonorrhoea has an important bearing upon the ætiology of some affections of the eye will be explained immediately.

It is now well understood that several diseases of the eye are connected with gonorrhoma as cause and effect. Until comparatively recent times the list of such affections was a restricted one, and included, in fact, but ophthalmia neonatorum and adultorum, and iritis. It now comprises such affections as metastatic conjunctivitis, inflammation of the lachrymal gland and of Tenon's capsule, scleritis, and (in rare instances) neuritis, neuro-retinitis, and retinitis. On the present occasion, however, I shall confine my remarks to what may be called inoculation-affections of the eye, or, more briefly still, cases of gonorrhœal ophthalmia. For an account of the other gonorrhœal diseases of the eye I would refer readers to an excellent monograph (3) recently published by Dr. W G. M. Byers, of Montreal.

Gonorrheal inoculations of the conjunctiva may take place at any period of life—literally from the cradle to the grave. They depend upon the conveyance of specific discharges to the eye, either directly, as by a spurt of "matter," or indirectly, as by fingers, towels, sponges, water, and so forth. They include towels, sponges, water, and so forth. three clinical types :-

1.—GONORRHEEAL OPHTHALMIA.

2.—LEUCORRHŒAL OPHTHALMIA.

-OPHTHALMIA NEONATORUM.

It must be borne carefully in mind that, although the forms of ophthalmia named above differ a good deal as regards clinical appearances and prognosis, yet each is due to the gonococcus. This fact will prepare the reader to accept the statement that a scientific and assured diagnosis can be reached only by bacteriological examination of pus from the inflamed eyes.

The methods of investigation are simple, and call for nothing more than an acquaintance with routine laboratory methods. As a preliminary step, the affected eye is washed free from discharge with warm saline lotion or with any sterile indifferent fluid. After waiting for a few moments, a trace of secretion which has in the meanwhile accumulated should be lifted from the conjunctival sac by means of a sterilised platinum loop, care being taken not to touch the lids, lashes, or neighbouring parts with the instrument. The discharge is then spread as thinly as possible over the surface of several bacteriological (No. 1) coverglasses, which are allowed to dry, protected from dust by a watch-glass. The next step is to stain the specimens. One should be treated with a basic aniline colour, of which the best is carbol methylene blue, and the other by Gram's method, safranin or weak fuchsin being employed as the counter-stain. Gono-

cocci will be seen as biscuit-shaped diplococci, which show a special tendency to become grouped in the pus and on the epithelial cells contained by the specimen. They are completely and rapidly decolourised by Gram's method. As a rule, the micro-organisms are present in large numbers, a point which is by no means devoid of practical importance.

It must be borne in mind that Gram-negative micrococci other than gonococci are occasionally found in the conjunctival sac, normal or diseased. The most the conjunctival sac, normal or diseased. important of these are two in number-namely (1) the meningococcus, and (2) the micrococcus catarrhalis. In rare cases these organisms may prove a source of But the first-named are larger and differ in shape, while the second present also more or less appreciable differences as regards size, arrangement, and grouping, as compared with gonococci. As a rule (to which exceptions are practically non-existent) it may be said that a severe discharging inflammation of the conjunctiva in baby, child, or adult, associated with numerous intra-cellular cocci and diplococci, which rapidly lose their gentian violet when treated with absolute alcohol in Gram's method, can be no other organism than the gonococcus. The difficulty is with mild cases. Under such circumstances, before organisms can be exactly differentiated, it may be necessary to resort to culture tests, and, indeed, in a specially difficult or important case, agglutination tests may have to be employed before one can distinguish between gonococci, on the one hand, and meningo-cocci, on the other. At the same time it is necessary to note that the meningococcus has seldom been found in the conjunctival sac, and never, so far as I know, in association with ophthalmia neonatorum. On the contrary, by Axenfeld (4) and Brons the micrococcus catarrhalis has been shown to occur more frequently on the conjunctiva than was once believed. Although in Brons's cases there existed a mild type of chronic conjunctivitis, yet it is still a moot point whether the micrococcus catarrhalis is or is not pathogenic as regards the human conjunctiva.

To recapitulate, the diagnostic features of the gonococcus are:—(1) Its predilection for the interior of the polymorphonuclear and other cells contained in the specimen; (2) its ready and rapid response to Gram's stain; and (3) its restricted growth upon all media, except such as contain hæmoglobin.

1.—GONORRHŒAL OPHTHALMIA.

Gonorrhœal ophthalmia as it affects adults is a most formidable affection of the eye, but owing to the care exercised nowadays, it is happily a rare disorder. There must be ophthalmic surgeons of the younger generation who have never seen a case. Speaking for myself, I have myself met with but few, and those mostly in nurses who had inoculated themselves from cases of gono-ophthalmia in babies. ease is usually confined to one eye, and in fully onehalf of the cases entails more or less damage to the cornea.

The following instance of the disease fell under my notice a year or two ago :-

A housemaid, æt. 25, was seen on September 8th, 1906, her right eye showing the clinical appearances that one associates with an attack of acute muco-purulent conjunctivitis—that is to say, the symptoms were not severe. The lids of the left eye, however, were red and so swollen that they could scarcely be opened. There was considerable purulent discharge. Chemosis was pronounced, but distributed irregularly. The cornea, although hazy, was not actually ulcerated. The unfortunate girl volunteered the statement that her sweetheart, a soldier, had given her gonorrhoea, and had put her into "the family way," and, to complete the sordid story, had deserted her.

Specimens of pus taken from the left eye contained

relatively few groups of intracellular cocci, but those present were characteristic enough. When treated by Gram and counter-stained by weak vesuvine, the organisms took the brown colour of the latter. Secretion expressed from the girl's urethra also showed the presence of gonococci.

The case was treated with quinine sulphate lotion (4 grs. to the unce), used frequently, and by the application once a day to the everted conjunctiva of a solution of argyrol, 25 per cent.

September 12th, 1906.—Both eyes about equally affected, and gonococci present in the discharge from patient now presented the typical appearances of gonorrheal ophthalmia affecting both eyes. The symptoms, however, were more marked in the left eye, the cornea of which was on the point of perforating. The right cornea showed a few minute grey infiltrations near its edge. September 19th, 1906.—Marked chemosis. Right cornea cloudy. The left cornea has perforated, and a protrusion of Descemet's membrane is now present. Patient complains of much pain, and is worn out by anxiety as to the fate of her eyes. September 22nd, 1906.—Patient, who complains of less pain, is now able to open her eyes a little. The right cornea shows a purulent infiltration involving the inner half, while the rest of the cornea is cloudy. further note is forthcoming.
2.—LEUCORRHOGAL OPHTHALMIA.

In a small but important class of case purulent ophthalmia is met with in children who suffer from ophthalmia," the existence of which was known to some of the earlier writers, was identical bacteriologically with ophthalmia in babies and with gonorrhoeal ophthalmia in adults. In this country Mr. Edward Nettleship (5) has drawn attention to the existence of such cases, although without admitting their gonorrhoal identity.

The following is a good example of this form of ophthalmia:---

Maud H—, æt. 21, was brought to the Evelina Hospital, London, on March 2nd, 1908, for a severe discharging inflammation of the right eye of one week's duration. There was a small infiltration towards the centre of the cornea. The clinical appearances recalled those of a gonorrheal case, an observation that led me to examine the child generally, when I found a profuse discharge from the vulva, of which the mother had said nothing. Gonococci were discovered in the discharge both from the conjunctiva and the vulva.

The child was admitted to hospital. The inflamed eve was treated with argyrol, 25 per cent., six times a day, and was meanwhile kept clean with oxycyanide of mercury lotion, 1-4,000. Atropine was also used. The non-affected eye was protected against infection by Buller's well-known sticking-plaster and watch-glass shield. The vulvo-vaginitis was treated with

hot permanganate lotion, 1—5,000.

The child was discharged from hospital on May 2nd, after a stay of two months. The left eye did not become involved, and the other eye healed with the production of a small nebula of the cornea.

Some years ago I met with a case of gonococcal ophthalmia in the right eye of a small boy, æt. 7, who was also affected with urethral gonorrhœa. origin of the latter was never traced.

Gonorrhœal ophthalmia in a child need not, however, be the product of an auto-infection. In the case to be next narrated, infection appears to have origin-

ated from a latent gonorrhoa in the father

Cerise B——, æt. 2/12, was first seen on November 10th, 1906, at the Kensington General Hospital. The mother presented no obvious evidences of gonorrhœa. The father had suffered from gonorrhæa about twelve months ago, and had continued to occupy the same bed as the child until the latter's eye became inflamed four days ago.

Present state.—The clinical appearances of the left

eye recall those of gonococcal ophthalmia-that is to say, there is purulent discharge, the upper lid is red, heavy, and swollen, and the cornea is universally cleudy. There is a thin layer of inseparable menibrane on both lids, better marked upon the upper than the lower one. The child is ill in herself, with a temperature of 101° F. Throat not affected. No vulvo-vaginitis. Bacteriology.—Smears from the pus, stained with Loeffler's blue and with Pappenheim, showed tolerably numerous cocci and diplococci, together with cell-groups of those micro-organisms Treated with Gram and vesuvine (0.5 per cent.), they were stained by the last-named reagent.

The child was admitted as an in-patient at the

Queen's Hospital for Children, and her subsequent history may be stated in a few words. On November 14th the right eye was definitely affected by the disease. On the following day both eyes were typical of gonorrhoal ophthalmia. The left cornea was hazy, and bulged towards the centre. On the 20th smears from the eyes showed an abundance of gonococci. Cultures were negative. On December 19th a note was made to the effect that an adherent leucoma was present in the lower-inner quadrant of the left cornea, the rest of which retained its transparence. On January 10th, 1907, an iridectomy was made in the upper-outer part of the left iris, and on February 6th and March 14th, 1907, the leucoma was tattooed.

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- 3. Byers.—"A Study of the Ocular Manifestations of Systemic Gonorrhea," 1908.
- 4. Axenfeld.—"Die Bakteriologie in der Augenheilkunde," 1907.
  - 5. Nettleship.—British Medical Journal.

    (To be concluded in our next.)

### **OPERATING THEATRES.**

PADDINGTON GREEN HOSPITAL.

EMPYEMA.—MR. ARTHUR EDMUNDS operated on a girl, æt. 3, who had been the subject of pneumonia for three weeks. Unfortunately the resolution had been incomplete, and the temperature had begun to go up once again, and an area of distinct dulness appeared on the left side. The chest was tapped about the level of the angle of the scapula, and pus was obtained. In suspected cases of empyema, Mr. Edmands said, exploratory tapping is of the very greatest value. In the first place, it is, of course, evidence of the pre-sence and locality of the collection of pus; in the second place, it enables the organism which is causing the empyema to be identified; and, finally, by removing a certain amount of the fluid, it diminishes the intra-pleural tension, and, by allowing the heart to accommodate itself to the altered conditions, minimises the operative risks. Several points need to be attended to in this connection. In the first place, the exploration of the chest must be conducted with the most aseptic precautions. The fallacy that the presence of pus allows the relaxation of antiseptic precautions nowhere yields such pernicious results as in the treatment of empyema. In spite of the teaching of modern day pathology, and in spite of clinical experience, it is no uncommon thing to hear the statement made that there is no occasion for antiseptic precautions, masmuch as the case is septic already. The pus which is withdrawn should always be carefully examined. Although the operation will often of necessity follow too closely upon the exploratory puncture for elaborate cultural investigation, it is always possible to examine a film. The practical point to be settled is whether the empyema is due to a pure pneumococcal infection or to an invasion by other organisms, either as a pure or mixed infection. This is an extremely valuable point for treatment. The pneumococcal empyema resolves readily, and if the lung has not been compressed too severely, yields very rapidly. In mixed infections and in empyemata due to other organisms, such as the staphylococcus pyogenes, the bacillus coli communis or the tubercle bacillus, healing is more protracted, and usually takes place by slow obliteration of the cavity. It was decided to drain the cavity by resecting a portion of rib just above the site of the exploratory puncture. The child was accordingly anæsthetised with chloroform. There is little doubt, Mr. Edmunds pointed out, that the anæsthetic in these cases has risks of its own, but if a certain amount (that is to say, 1 to 2 oz.) of pus is evacuated at the time of the exploration, and a minimum quantity of anæsthetic given, the risks are not unduly great. After the skin had been disinfected, the index and middle finger were placed over the intercostal spaces on either side of the rib to be removed, so as to steady the superficial structures. When this is done, it is possible to carry the knife at once down to the bone and to divide everything from skin to periosteum cleanly. If the tissues are not steadied in this way, the contraction of the superficial muscles is apt to divert the knife from its course and make an irregular wound. When about an inch and a-half of rib had been thus exposed, a curved raspatory was passed between the rib and the periosteum, care being taken to keep close to the bone in the sub-costal groove so as to avoid injury to vessels and nerves. The bone was then cut across at each end of the incision, and the central portion removed. The soft tissues on the deep surface of the rib were punctured, and the opening rapidly enlarged to allow the introduction of the index finger, which was thrust into the chest so as to explore the cavity, and at the same time prevent the too rapid evacuation of pus. At this stage of the operation the anæsthetic was-stopped, and the patient permitted to come round to a certain extent, so as to allow the reflex laryngeal contractions by means of which the lung on the affected side is inflated, to come into play. As in the present case, the organism had been found to be a pure pneumococcus, the presence of masses of fibrinous material was suspected, and these soon came into view, being forced up into the opening in the chest wall and removed. A drainage tube sufficiently long to reach through the chest wall was stitched into position, a dressing applied, and the patient taken back to bed.

Mr. Edmunds remarked that in suturing tubes into empyemata care must be taken to fasten them so that about half an inch protrudes from the chest wall, otherwise they are very liable to slip under the edges of the wound and become occluded. The drainage tube in a pneumococcal case in a child is removed on the fourth day, and in the majority of cases no further drainage is found necessary. In dressing these cases what he had before said on the question of antiseptic precautions must be rigidly observed; indeed, there is no operation in the whole of surgery which requires such minute care as the dressing of empyema: the persistent discharge may be due to a hopelessly adherent lung, but in the majority of cases it is due to repeated re-infection at the time of dressing. Much has been written as to the mechanism by means of which the lung is re-inflated and with regard to the existence of adhesion (in the physical sense) between lung and chest wall, and has been brought forward to explain this phenomenon. With a wide perforation in the thorax the ordinary suction pump action of the chest is thrown out of action, as far as the lung on that side is concerned, but upon the sound side, owing to the comparative rigidity of the mediastinum, the normal respiratory mechanism is quite efficient and coincidentally with the enlargement of that side of the thorax air enters the normal lung. At the commencement of expiration the glottis is closed and the air, unable to escape through the trachea, is forced into the affected lung, distending it and bringing it into contact with the chest wall, the glottis finally opening, air escapes and expiration is complete. Respiration, therefore, consists in these cases of three phases-inspiration, distribution, expiration.

### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

OBSTETRICAL AND GYNECOLOGICAL SECTION.

MEETING HELD THURSDAY, JANUARY 14TH, 1909.

The President, Dr. HERBERT SPENCER, in the Chair.

Dr. Florence E. Willey read a short communication on the

HISTOLOGY OF THE SMALLER MYOMATA.

Reference was made to the fact that the more recent theories have claimed that fibro-myomata originated by proliferation of the cells forming the coats of

arteries or capillaries, and that the muscle fibres are arranged concentrically round a central vessel.

Sections of young myomata, from 5 m.m. diameter upwards, illustrate the following points:—

(1) That the proliferating cells in growing tumours are muscle cells.

In sections from patients, æt. 30—40, with enlarging uteri, the areas of proliferation show less connective tissue in proportion to the muscle than is found in non-proliferating muscle bundles of the same uterine wall, and the muscle nuclei are oval to rod-shaped; whereas seedling tumours past the menopause consist largely of fibrous tissue, and the muscle cells have narrow rod-shaped nuclei.

(2) The cells which proliferate are not those of the vascular system, but cells common to the whole uterine

parenchyma.

(3) The shape of early growths is most variousdepending on the direction of the muscle bundles concerned rather than on any relation to vessels large or small. Capsule formation begins later, when the growing tumour assumes an oval or spherical shape.

(4) Subperitoneal fibro-myomata often begin by proliferation of the muscle bundles immediately beneath the peritoneum, and capsule formation in these is

first seen on the site adjoining the uterine wall.

(5) In sections of 60—70 uteri of all ages no fibromyomatous seedling has been found before puberty, and those in women past the menopause consisted

largely of fibrous tissue.

Conclusion: That fibro-myomata arise as irregular patches of proliferation of muscle cells of the uterine parenchyma, which have no special relation to the vascular system. The cause of this proliferation is unknown, but the absence of growing tumours before puberty and after the menopause suggests some relation to the activity of the sexual organs.

The PRESIDENT (Dr. Herbert Spencer) said he could corroborate Mrs. Willey's statements as to the absence of capsules in many small fibroids, and had been surprised to hear it asserted that they always had capsules. He asked whether Mrs. Willey had examined microscopically some of the curious minute fibroids sometimes seen beneath the peritoneum, which had the appearance of keloid scars.

Dr. HEYWOOD SMITH considered that they were often the result of the suppression of sexual impressions, and that intermittent and perhaps periodic congestions, leading in some instances to small interstitial hæmorrhages, might be the starting point of the fibrous deposit, which was a morbid attempt to strengthen the

part subjected to the hæmorrhagic strain.

Dr. MACNAUGHTON-JONES noticed Mrs. Willey had excluded sepsis as an occasional factor in the extiology of some myomata. Dr. Mary Dixon Jones, who had very exhaustively studied the origin of myoma, considered that there was an infective starting point in their origin, and other observers confirmed this. From the very small size of the growths examined by Mrs. Willey, he thought it difficult to draw general conclusions as to the origin of the larger myomata.

Mrs. WILLEY replied.

In a short communication Mrs. STANLEY BOYD, M.D., gave the remote results and post-mortem findings four and a-half years after operation, in a case of

### ABDOMINAL HYSTERECTOMY

for cancer of the cervix, followed by vesico-vaginal The case was an early one, and, except for adhesions about the appendages, and some tough, fibrous tissue in the neighbourhood of the bladder, favourable for a radical operation. Vesico-vaginal fistula developed six days after the operation, but was small, and gave the patient comparatively slight inconvenience, so that she persistently declined opera-tion for its closure. The case was watched for four and a-half years, during which time there were intermittent attacks of pyuria, which were attributed to suppuration in the neighbourhood of the bladder bursting into it.

In August last the patient was admitted into the Great Northern Hospital with suppuration about the right kidney, under Mr. Peyton Beale, too ill for anything but incision of abscesses and palliative treatment. She died September 12th, 1908.

The post-mortem showed no recurrence of growth,

but complete occlusion of the right ureter at its vesical end, where it was imbedded in a mass of cicatricial tissue, right pyonephrosis, perinephric suppuration, sub-diaphragmmatic abscess, and right empyema.

The PRESIDENT (Dr. Herbert Spencer) said the pub-

lication of after-histories was of great value, especially in cases of carcinoma. It was unfortunate that a microscopic examination was not made of the fibrous tissue around the ureter and of the glands. He had often wondered what happened to patients with ureteral fistulæ when the fistulæ closed, as Wertheim had shown that they frequently did, and whether the extensive removal of the tissues around the ureters might not lead to cicatricial obstruction of these tubes.

Dr. A. H. Lewers said that he had had a case of vaginal hysterectomy for carcinoma of the body of the uterus many years ago, in which a ureteral fistula had developed. Nothing of an active kind was done for it, and some months later the fistula healed. The patient was seen several times subsequently, and there

was no evidence of anything wrong with the kidney.
Dr. G. F. BLACKER stated that he had had three cases of ureteral fistula occurring after total abdominal hysterectomy. In the first case, owing to septic changes, the corresponding kidney had to be removed, and this was followed by complete recovery. The second case developed an attack of acute suppression of urine, lasting 24 hours, about five weeks after the operation. This passed off, and the patient recovered, and the fistula healed. In the third case the patient developed a high temperature a month after the operation, and the bacillus coli was found in the urine. Eight weeks after the original operation the patient died with symptoms of pyæmia, and at the post-mortem examination a small abscess was found at the site of the fistula.

Mr. STANLEY BOYD replied.

Dr. R. H. PARAMORE read a paper on the

RÔLE OF THE PERINEAL BODY IN LABOUR

In it he stated that the perineal body plays no part in the support of the viscera, nor does its rupture facilitate prolapse. Yet the perineal body exercises a far-reaching influence during child-birth which is neither necessary nor good. In the descent of the fœtal head through the outlet of the pelvis, the pelvic floor becomes transformed into a broad, gutter-like declivity, at the lower end of which the posterior commissure of the pubo-rectalis muscle is found. The dilatation of the anus and the increase in length of the base of the perineal body shows how much the tissues below the pelvic floor stretch. The tension of these thinnedcut perineal tissues determines the more forward projection of the anterior segment of the head, the head being ovoid in shape. If the vulvar aperture is destroyed by a laceration, the movement forward of the anterior segment of the head does not occur. is evident that a perineal tear by allowing birth with the least possible distension of the muscle may undoubtedly in many cases prevent an injury which pre-disposes to prolapse. An early perineal tear may be a blessing in disguise. Perineal tears, when they do not involve the sphincter, are trifling injuries, and the only reasons for suturing them are to check hæmorthage and prevent infection. The main mass of the pelvic floor musculature passes behind the anal canal and remains intact, in spite of such a tear. The continued extension of the head can be prevented by adopting the method of Toff. When the head appears at the vulva, two fingers are placed between it and the pubes, and traction exerted backwards. taneously the head may be pressed downwards and forwards from above the anus.

Dr. Macnaughton-Jones said he would be sorry to think that it should go out from this Section that there should be any divergence from the obstetrical rule of at once closing a perineal tear. Rectocele and vesicocele constantly occurred with what Howard Kelly called "relaxed vaginal outlet," where there was no apparent laceration, but in which the perineum was weakened.

Dr. AMAND ROUTH thought that there could be no possibility of doubt that the perineal body serves many useful purposes, and that its integrity was essential to the preservation of the tone of the vaginal and vulvar outlet.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, JANUARY 8TH, 1909.

The President, Mr. JOHN LENTAIGNE, in the Chair.

THE TREATMENT OF EXTROVERSION OF THE BLADDER BY TRANSPLANTATION OF THE URETERS INTO THE RECTUM.

MR. C. ARTHUR BALL read a paper on the above subject. Having discussed the principal theories as to the cause of the condition, Mr. Ball gave an account of the various operative procedures that have been recommended, and expressed the opinion that the safest and most satisfactory procedure was the transplantation of the ureters into the rectum by an extraperitoneal operation. Details were then given, by means of lantern slides, of a case in which the operation had been carried out in a boy, æt. 5. The child was operated on last July, and the result was satisfactory. the child being in perfect health six months later, and having very tair powers of retaining urine in the rectum. Three months after the operation urine could be retained up to three and a half hours, and this control had continued to improve since then.

The President said the case was, so far as he knew. the first satisfactory one that had been done in Dublin, and illustrated the improvement which had been effected in dealing with an apparently hopeless condition. By the newer process, unusually short and safe treatment had effected far more improvement than any of the complicated efforts made before. He desired to know whether it had been proposed to infold the rectum at the point where the ureter entered it, so as to make it less likely to slip out, and give a broader field for adhesion on the part of the ureter. He congratulated Mr. Ball on the result.

Mr. Seton Pringle wished to know if there was any

trouble in keeping the peritoneum back, and seeing

what was being done?

Mr. BALL, in reply, said he did not think infolding of the rectum had been done. In his case there seemed to be no tendency to slip out. He did not see the peritoneum until he first came on the rectum. One would have expected it to get in the way sooner. than it did. There was considerable separation of the public bones, and the pelvic cavity was consequently very shallow, so that the case was ideally arranged for the surgical procedure carried out.

ABSCESS OF THE PANCREAS, WITH REPORT OF A CASE FOLLOWING ACUTE GANGRENOUS PANCREATITIS.

Mr. Seton Princle read a paper on the above subject. After expressing the opinion that all cases of pancreatitis should be reported, so that a fuller knowledge of the disease should be griefd by grained by griefd by ledge of the disease should be gained, he gave a de-

tailed acount of the case on which the paper is based.
The patient, æt. 46, with a marked alcoholic history,
was admitted to hospital on the twelfth day of his
illness with signs of peritonitis of the upper abdomen. where a large tumour mass could be felt. Operation was performed immediately, and a large abscess found in the lesser peritoneal sac, the edges of the opening into the abscess were sutured to the parietal peritoneum, and a large drainage tube inserted. There were numerous patches of fat necrosis in the omentum and a small quantity of bloody fluid in the larger sac of peritoneum. The patient progressed favourably for a few days, but gradually lost strength, and died on the twelfth day after operation. The urine, several days after operation, gave a marked Cammidge "C. reaction." At the post-mortem it was found that the reaction." At the post-mortem it was found that the head and body of the pancreas had sloughed, only the tail surviving; no gall-stones were discovered. Mr. Pringle then discussed the ætiology of the case, and expressed the opinion that the pancreatitis in his patient was the result of alcoholic gastro-duodenal catarrh. After enumerating the various forms in which suppuration may occur in the pancreas, he gave a short account of the methods of treatment at present employed, and concluded by calling attention to the fact that only some sixteen cases of operation for pan-creatic abscess were recorded in the literature.

The President said that cases of comparatively

newly-recognised diseases, the symptoms of which were most obscure, were just such as should be brought forward in detail in the excellent way in which Mr. Pringle had reported this case, and they were the more grateful to him for having brought forward a case in which his efforts to cure had not been rewarded with success. The case showed the importance of early operation. If the abdomen had been opened at an early stage it was possible that the gangrene might have been averted; at any rate it would have been more hopeful. It was only by the bringing forward of such cases that they would be able to arrive at an early diagnosis.

Mr. STOKES said he had seen a similar case operated on a couple of years ago, in which acute septic peritenitis was found at the post-mortem. But for that the case might have pulled through. The question of draining behind had been raised, but the Americans had given up that unless the inflammation were con-

fined to the tail of the pancreas.

Mr. BLAYNEY said there could be no doubt that at Mr. Blayney said there could be no doubt that at the time the patient was seen no surgical measures could have saved him. He thought it was of very great importance that these cases should be diagnosed in their very earliest stage. If the patient had been seen when he got the first pain, an operation then might possibly have been successful. Only by examination of a series of cases would they find some group of symptoms which would indicate the onset of the disease and for that reason he thought the publithe disease, and for that reason he thought the publication of such cases most useful.

Mr. Ball suggested that the apparently greater frequency of the disease in hospital patients than in private patients might arise from differences of habits

in eating and drinking.

Mr. Pringle, in reply, said that in his case there was no peritonitis in the lower abdomen. Cammidge had improved his reaction, and had obtained it in every case in which there was pancreatitis, either acute or chronic, and it was present in only four out of 150 cases in which there was no pancreatitis. It was, therefore, apparently a fairly satisfactory clinical test.

Mr. Wheeler being absent, his paper on "The Choice of Operation in Cancer of the Rectum" was

read by the Secretary.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD FRIDAY, JANUARY 15TH, 1909.

The President, Dr. A. J. WALLACE (Liverpool), in the Chair.

Dr. J. W. Martin (Sheffield), was elected President; Mr. M. H. Phillips (Sheffield), General Secretary; and Dr. W. K. Walls (Manchester), Treasurer, for 1909.

Professor Lorrain Smith and Dr. W. Fletcher

SHAW (Manchester) read a paper on the PATHOLOGY OF RED DEGENERATION OF UTERINE FIBROIDS. They had examined four specimens, three of which were associated with pregnancy. Staining by Weigert's fibrin method they found extensive thrombosis of the blood vessels in the red areas of all four specimens, and this they consider the essential and characteristic change. There was no evidence of recent or old extravasation of blood. The myomatous tissue was also in a state of atrophy and degeneration, being replaced by a homogeneous substance, which stained faintly with eosin. But this form of necrotic softening is very common in fibroids, and further observation is necessary to show whether red degeneration ever occurs apart from such a process of necrosis. Excess of fat, as droplets or crystals, was also found. Two of the patients had presented toxæmic symptoms, and in each of these cases the authors found an active leucocytosis and bacteria in the tumours; staphylococci in one and diplococci in the other. Neither bacteria nor a leucocytosis was found in the other cases. Finally, the authors pointed out that redness dependent upon Virchow's angiomatous degeneration may be present in such a degree that the tumour has considerable naked-eye resemblance to the true red degeneration.

Drs. Lloyd Roberts, Briggs, Donald, Walls, Fothergill,

Lea, Grimsdale and Croft discussed the paper, and Professor Lorrain Smith, in reply, expressed his opinion that the bacterial infection was probably secondary to and predisposed to by the thrombosis; that the excess of fat was dependent upon arrest of absorption resulting from the thrombosis, and that pregnancy, by mechanically hampering the circulation in the tumour, and the puerperium, with its increased coagulability of the blood, were possibly predisposing factors in the causation of red degeneration.

### CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, JANUARY 21ST, 1909.

Dr. CHAMPNEYS in the Chair, all Members being present.

#### THE NON-REPRESENTATIVE DEPARTMENTAL COMMITTEE.

THE CHAIRMAN read the following letter from Miss Wilson, announcing her resignation from the Board, which she had sent in to the Lord President of the Council last month:

To the Right Hon. Viscount Wolverhampton, Lord President of the Council.

My Lord,—I wish to place in your lordship's hands my resignation of the seat on the Central Midwives Board, to which I have been twice nominated by successive Lords President during the past six years.

The term of my second appointment does not expire till April, 1909, but I prefer to resign now in order to be free to protest against the constitution of the new Departmental Committee which your lordship has appointed to consider the working of the Midwives Act, 1902, and the supply and training of midwives, etc. That such a committee should have been selected without any notice given to at least one of your nominees on the Central Midwives Board is a matter on which your lordship is naturally the proper judge, but the absence of any proper certified midwife from the list of the committee has caused painful surprise to all who are familiar with the questions which will come under consideration. Many of these women are well-fitted by training and education to be of great service in the deliberations which form part of the proposed work. If your lordship could contemplate the appointment of a committee to investigate and report on the curriculum and supply of medical practi-tioners from which all doctors were excluded you would realise a parallel situation. The admission of the evidence of midwives as witnesses before the committee would be no equal substitute for the appointment of midwives on the committee itself. As President of the Midwives' Institute for the past 15 years, and as nominee of the Privy Council on the Central Midwives Board for the past 6, I feel it my duty, on behalf of the 26,000 women on the Midwives' Roll, to enter my earnest protest against an exclusion which is as unjust as it is unwise, and holding this opinion I find myself unable to sit any longer on the Central Midwives Board as your lordship's official nominee.

I have the honour to be, my lord,
Your lordship's obedient servant,

J. WILSON.

December 16th, 1908.

The following resolution was thereupon proposed from the Chair, and carried unanimously:—"That the Board learns with great regret of the resignation of Miss Wilson, who has been a member since its foundation, and desires to express its appreciation of her services, which have been invaluable, and which have involved an amount of self-sacrifice and devotion which only those who have worked with her can esti-They consider her loss irreparable."

REPRESENTATION OF GENERAL PRACTITIONERS. Mr. PARKER YOUNG proposed:—"That the Lord President of the Council be respectfully requested to consider the advisability of adding to the Departmental Committee representatives of the interests of general medical practitioners and midwives, as the Board consider that such additions would greatly enhance the value of the report eventually come to by that Committee." This was carried by 5 votes to 2.

Dr. STANLEY ATKINSON said that, as a Board constituted for the administration of the Midwives Act. he thought they had reason and right in making any suggestions which they thought would be beneficial to the working of the Act.

Sir George Fordham wished to point out that, should this request go before the Lord President and be refused, their Chairman, who was also a member of the Departmental Committee, might find himself in an embarrassing position.

Sir WILLIAM SINCLAIR remarked that it was not their place to dictate to the Privy Council, or to interfere with another Government department. He thought the

matter of fees to medical men called to the assistance of midwives might well be left to the Medical Press.

Mr. Parker Young denied that there was anything in the nature of "dictation" in his motion. As for interfering in matters outside their own business, he asked what was the business of the Board if it was not the working of the Midwives Act, and they all knew the Act, as it stood at present, was unworkable. This was proved again and again by the letters received from practising midwives, complaining that they had sent to seven or eight doctors in succession to come to their aid in difficulty, according to the Rules of the C.M.B., and not one of them would come. In the interests of the thousands of women who were attended by midwives, and who, to a great extent, were voice-less in these questions, he considered it their solemn duty to do everything in their power to render the Act more workable. And when a committee was appointed to consider such questions as the fees of medical men and the training of midwives, he considered it essential that these questions should be discussed by experts. The Chairman would be invaluable in a great many ways, but he was a consultant, and so was Sir William Sinclair, and they could not realise, as the general practitioner and the midwife did, where the shoe pinched.

The resolution having been carried, the Secretary was instructed to forward it to the Lord President of the Council.

The Report of the Standing Committee dealt with letters from the acting solicitor of Eliza Annie Collins, No. 8,000, promising to suppress the circular suggesting that she is qualified to give medical treatment.

There were several letters, from Dr. A. Stookes, of Liverpool, and others, relative to the caution lately impressed by the Board upon training schools and recognised teachers; that pupils must have made repeated vaginal and abdomnial examinations in the 20 cases before they could count, and inquiring how this was reconciled with Rule E. 8, which recommends few, if any, vaginal examinations. The reply agreed to by the Board was that the Rules applied to practising midwives, not to training schools and pupils. In reply to an inquiry from the Secretary of St. Mary's Hospitals, Manchester, as to whether this requirement of the Board was meant to be retrospective, the Board agreed that it was not.

The Newcastle-on-Tyne Hospital was approved as a training school, and the following were approved as a teachers:—F. H. Allfrey, M.B.; J. H. Robinson (Capt. R.A.M.C.), M.R.C.S., L.R.C.P.; Mary Ann Dacomb Scharlieb, M.D., and H. M. Stumbles, M.B.

### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.
Paris, Jan. 24th, 1909.

PALMO-PLANTAR SIGN OF T.F.

Some years ago attention was drawn to a special vellow colouration of the palms of the hands and the soles of the feet by a Russian doctor, which he considered as almost pathognomonic of typhoid fever.

A few months ago another doctor made a special A 1ew months ago another doctor made a special study of this question and came to the same conclusion. Out of 220 patients examined, the sign was present in 216, or over 98 per cent.

The colouration begins to appear in the first week

of the malady, and before the appearance of the lenti-cular spots. The colour, which at the beginning is crange yellow, deepens during ten days or so, and then remains stationary until the end of the disease. When convalescence sets in, the hands and feet desquamate, and the skin finally recovers its normal aspect. Where the fever was prolonged beyond the normal time, or terminated fatally, the yellow colouring crept over the sides and back of the fingers.

#### SURGICAL PHLEGMASIA

The usual treatment of external inflammatory lesions, as phlegmon, adenitis, mammitis, etc., is warm applications, and, when suppuration has set in, the bistoury; but an operation may be, however, frequently avoided by the application of a preparation of ichthyol and glycerin to the seat of the inflammation:

— Ichthyol, I oz.

Glycerin, 4 oz.
In a few hours the painful symptoms diminish considerably and soon disappear, while in many cases the progress towards suppuration is arrested.

#### HÆMORRHOIDS.

Hæmorrhoids are always more or less troublesome, but when the piles become congested and inflamed, they require prompt treatment. In such cases very warm enemas (113°) are advisable, as well as applications of hot water to the distended veins, while the following ointment will give ready relief:—

Stoyain, s gr.

Stovain, 5 gr.
Sol. of adrenalin (1-1,000), 20 drops.

Vaseline, 3 dr.
Internal hæmorrhoids will be treated with suppositories :-

Stovain,  $\frac{1}{3}$  gr. Ext. belladona,  $\frac{1}{3}$  gr. Cacao butter, q.s. LEUCORRHOBA OF YOUNG GIRLS.

Leucorrhœa in young children is frequently depending on a general lymphatic or anæmic condition. The treatment should consequently include preparations of arsenic, iodine, iron, etc. The local treatment consists in astringent hip baths and external lotions to the parts twice a day with—

Alum, 1 dr. Sulph. zinc, 1 dr.

Water, I quart.
Generally this treatment is sufficient to effect a cure, but sometimes it may be necessary to inject into the vagina by means of a small syringe a solution of permanganate of potash (5 gr. to a quart of boiled water), and to cauterise the labit with a solution of nitrate of silver (1 in 50).

### GASTRIC VERTIGO.

Dizziness in the head is generally of gastric origin, and can accompany every form of dyspepsia. The vertigo is observed on rising from bed in the morning, or one hour after meals. It gives the patient the aspect of a drunken man, and is due to an excess of acid in the stomach. The prognosis of the affection is benign, as by appropriate treatment a cure is speedily obtained

Dietetic regime is very important. According to Prof. Robin, these patients have their stomachs more or less distended, and consequently rules of eating should be observed. In the morning the patient will take some toast, an egg, and some cooked fruit; at mid-day, meat without sauce, eggs in the shell, vegetables without grease, while only a little pure water is allowed. After meals a cup of hot tea. Coffee and tobacco should be suppressed, as well as alcoholic drinks.

The medical treatment is not very complicated. quarter of an hour before breakfast the patient should take a wineglass of quassia infusion, and before dinner 6 drops of tincture of nux vomica. After each meal one of the wafers :-

Calcined magnesia, 8 gr. Bicarb. of soda, 8 gr. Prepared chalk, 6 gr.

If much flatulence be present, a tablespoonful of— Fluoride of ammonium, 6 gr.

Water, 10 oz.

At the moment when the dizziness is about to be felt, it may be warded off by a tablespoonful ofBromide of potassium, 11 dr. Cherry laurel water, 2 dr. Syrup of ether, 1 oz. Inf. of valerian, 4 oz.

Where the vertigo is suspected to be also in relation to existing arterio-sclerosis, small doses (2 to 3 gr. a day) of nitrite of soda will rapidly improve the situation by diminishing the tension of the blood.

#### PHLEBITIS.

Besides the usual immobilisation in a box splint lined with cotton wool, the application of the following ointment is very efficacious:

Collargol, 30 gr.

Vaseline, 3 dr.
Or, better still, injections each day of electragol (1 dr.), parallel to the vein without touching it. Rapid

### GERMANY.

Berlin, Jan. 24th, 1909.

AT the Medizinische Gesellschaft Hr. J. Hirschberg

THE TURRET OR DOME SKULL.

His observations were made in reference to a case observed last summer, that of a female who had this peculiar deformity of the skull. She was 18 years of age, and it was stated that up to her fifth year the sutures of the skull had remained open; from her earliest youth she had been subject to convulsions, which gradually became less frequent. Nothing was to be remarked in her family history. Her intelli-gence was normal. From her eleventh year she had disturbance of vision, which had remained unchanged since that time. The power of vision was about onethird, the field being contracted concentrically on both sides. There was advanced bilateral atrophy of the papillæ. The girl had a classical turret skull. Since the first publications on this subject (Graefe, Michel), the first publications on this subject (Graefe, Michel), this peculiar condition had been observed. The speaker had seen seven cases himself, six of them males, and all young, so that in accordance with statements met with in literature it appeared as if these individuals did not reach a great age. The skull was always narrow and high, which was generally due to early closing of the cuttures: there was simply to early closing of the sutures; there was simultaneously irritation or inflammation of the membranes of the brain, which through pressure caused atrophy of the visual nerves. There was no congenital syphilis in any case, but frequently traces of rickets. If such a child came under observation early it had been proposed to trephine, in order to equalise the intracranial pressure, and in one case this had been carried out with success. This success indicated that it was not a narrowing of the foramen that caused the pressure

and the atrophy of the optic nerve.

Hr. Grunmach showed Röntgen illustrations of turret skulls, and gave a careful description of them.

Hr. Heubner related particulars of a family with twelve children, two of whom were exquisite illustrations. trations of the deformity, and became blind within 14 days; a third child had micromelia, in consequence of chondrodystrophia fœtalis.

Hr. Hollander suggested a careful examination of the Inca skulls, in which this deformity was brought

about by artificial means.

At the Ophthalmological Society Hr. Leber gave an

address, entitled
Investigations into the Ætiology of Trachoma. These investigations were carried out at the instance of the Kultus Minister in Trieste. In numerous illustrations he showed the familiar granules in the epithelial cells of the trachomatous subject, which had been considered by some authors to be parasites, and as such connected with the ætiology of the affection. The speaker had so far altered the mode of investigation, that for fixing he had made use of the moist sublimate fixing material, that Schaudinn had used in investigations into the protozoa; the only new observation he had made was that he had found these granules on or within the red blood corpuscles.

Hr. di Santo made the statement that, in his trachomatous apes and also in the human subject, he

had met with the granules in the subconjunctival connective tissue.

Hr. Herzog remarked that the figures shown were but little different from those of inflammation in non-trachomatous cases, and showed illustrations in support of his statement; they very much resembled trachoma granules.

The Deutsche Med. Zeitung, 4/09, has a communication on the subject of

WET NURSES.

Drs. E. and L. Oberwarth, who have been for many years connected with a home for wet nurses, have come to certain conclusions with regard to their engagement, etc., that possess a considerable interest. They are shortly as follows:—In the interests of her child no mother should be allowed to hire herself out as a wet nurse before her own child is six weeks old and weaned. When the father cannot be approached she should pay the costs of the keep of her own child out of her wages, but the party engaging her is under obligations to see that this is punctually carried out. In case of illness it is the duty of the parties employing her to pay part of the increased cost of the child's maintenance. The termination of a wet nurse's engagement should be subject to a fortnight's notice on either side.

### AUSTRIA.

Vienna, Jan. 24th, 1900.

TUBERCLE AND SPLENECTOMY.

ALBRECHT exhibited a female patient, æt. 37, on whom he had operated for isolated primary tubercle of the spleen. The organ when removed weighed 1,370 grm., or nearly 3 lbs. It was rich in fibrous tissue and throughout bestrewn with miliary tubercle. No and throughout bestrewn with miliary tupercie. No other part of the body bore any indication of a tuber-cular process. Schwartz gave a brief history of the case and the blood analysis. Before the operation he found the hæmoglobin 67, with Fleischl's instrument, the red blood corpuscles 4,500,000, with an increase of the transformation form in the white blood corpuscles to the part cent, while the exceptability were a puscles to 13 per cent., while the eosinophile were 2 per cent. After the operation the hæmoglobin was 65, with the same instrument, the red blood corpuscles unchanged, while the transformation form was 11 per cent., and the eosinophile 4 per cent. The patient now appears to be in good health.

ANEURYSM OF THE BASILAR ARTERY.

Wiesner showed a few anatomical preparations of saccular aneurysms which he had collected, taken from the basilar artery. These aneurysms had all split the pons varolii, which deformed the right half of that structure, as well as the medulla oblongata. Chvostek gave a full clinical description of one of the cases that Wiesner exhibited. The patient had always been per-fectly healthy up to the beginning of last year, when he first complained of headache, which was followed by vomiting and vertigo. He gradually lost his by vomiting and vertigo. He gradually lost his hearing and sight, with difficulty in swallowing, double vision and imperfection in speech. After this paresis of the right side of the head, paralysis of the right abducens and internal muscles, while paresis was observed in the left abducens. The same condition existed in the uvula, but the paresis was slight on the left side of the body, with increased reflex. The papillæ were not congested or enlarged, but the associated paralysis and the freedom of the motor nerves from disease pointed to some centre of disturbance in the pons which was assumed during life to be tuber-

CUTANEOUS REACTION WITH TUBERCLE.

Monti gave the members a short account of Pirquet's reaction and various modifications that had been performed. He said the scarification of the skin and the reaction obtained from tubercle were often very different. He thought this varying result was due to the imperfect introduction of the toxin, which often led to a characteristic cutaneous reaction. Lignières had performed experiments in this direction by shaving a part and then rubbing the tuberculin into it; reac tion in this case was constant and specific, always giving a lupus change as the result. Lautier in a similar manner within 48 hours obtained on the skin of a tubercular individual, with a 1 per cent. solution,

a vesicular efflorescence, each vesicle having an inflammatory base. This reaction has the disadvantage of being less sensitive as its results cannot be obtained before 48 hours, yet it has the advantage of vaccination in avoiding much local disturbance. More endeavoured to obtain similar results by rubbing a 50 per cent. tuberculin ointment into scrofulous children and obtaining a specific result. On the site of the part rubbed fine nodular inffloresences were produced, which gradually disappeared in a few days.

Monti now gave his own experience on 300 children. Moro's ointment, he said, was a specific because all the cases, when used cutaneously or percutaneously, had a positive reaction, but the percutaneous, he might say, was less sensitive than the cutaneous vaccination. Monti then showed the effects on several children whom he had under examination, and demonstrated from others. Tedeschi's auriculo-reaction is to inject the toxin into the lobe of the ear, and induce infiltration of the subcutaneous cellular tissue. This reaction is similar to Hamburger's stabbing form, but has the disadvantage in ambulant patients of producing swelling of the retro-auricular glands. recommends cutaneous vaccination, controlled by the stabbing reaction, but where this is objected to, Moro's ointment is to be recommended. Escherich thought the stabbing method was the surest for tubercular diagnosis, and asked whether Monti used bovine or human tuberculin? Monti replied human was used.

### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.
SCOTTISH UNIVERSITY WOMEN'S SUFFRAGE SOCIETY. -At a representative meeting of the committee of women graduates of the Scottish Universities, held in Edinburgh on January 16th, it was decided to form a suffrage association on a non-party basis. The main object of the society is sufficiently implied in its title; it proposes to attain its object by an active propaganda. Meetings in favour of women's suffrage are to be held in every town and village in Scotland; petitions are to be sent to Parliament from every such meeting; a general canvass is to be carried out; statements are to be asked from Members of Parliament and Parliamentary candidates of their views; suffrage organisers are to be obtained in every constituency; suffrage literature is to be compiled and distributed; debates are to be encouraged-in short, every form of recognised constitutional agitation is to be adopted. Membership of the society is open to women graduates, and women on the Medical Register; others in sympathy with the movement will be welcomed as associates.

EDINBURGH PARISH COUNCIL AND THE INFIRMARY ASSESSMENT.—At the last meeting of the Council an application from the Infirmary for relief from assessment was considered, and rejected on the ground that Act to exempt the institution. One member of the Council expressed the opinion that, in view of the relief which, in one way and another, the Infirmary gave to the rates, the Council should send a donation to the funds of the institution. Another speaker said the Council should not contribute unconditionally; they wanted a quid pro quo. A committee had been appointed to confer with the Infirmary regarding the establishment of wards for the treatment of temporary mental disorder, and if these were opened they would recognise the relief afforded to the rates by a suitable donation.

EDINBURGH DISTRICT LUNACY BOARD.—According to the report of Dr. John Macpherson, Commissioner in Lunacy, the Bangour Asylum now houses 747 patients. and there are now only about 100 vacant beds. At the present rate of increase the available accommodation will soon be filled, and there are still roo patients in the Royal Asylum for whom provision must be made within two years. The accumulation of the asylum population can to some extent be controlled by preventing the admission of unsuitable cases, and by removing to private dwellings patients for whom asylum

treatment is no longer necessary. The boarding-out system, therefore, must be extended, but it is estimated that nearly one-third of the patients in Bangour are physically infirm and senile; so that the number from which suitable cases can be selected is limited by that amount. Judging from the growing tendency manifested during recent years in Scotland to send old and infirm persons to asylums, Dr. Macpherson commends to the consideration of the district board the question whether future additions might not advantageously take the form of simple and inexpensive infirmary accommodation.

#### **BELFAST**

ULSTER MEDICAL SOCIETY .- On Thursday evening last a most successful smoking concert was given in the Medical Institute, Belfast, by the President of the Ulster Medical Society, Mr. T. S. Kirk. The guests were received by Mr. and Mrs. Kirk in the library, and, after tea and coffee had been served there, they proceeded to the large hall, in which a capital smoking concert took place. Dr. MacIlwaine, Mr. R. J. Johnstone, and Mr. Waugh contributed several items, Mr. Lloyd Campbell told some stories, and the members of the Northern Male Quartette and several others took part. During the evening Mr. Kirk announced that the Society had unanimously decided to confer its Honorary Fellowship on Sir William Whitla, in recognition not only of his professional attainments, but also of his many acts of kindness to the Society, including the building and equipping of the home in which the members were then met. He concluded by presenting to Sir William Whitla a certificate of members were bership, illuminated on parchment and ornamented with beautifully painted miniatures of the Institute, and of the Smyth Memorial window in it. Sir William, who was completely taken by surprise, replied in a few words.

### LETTERS TO THE EDITOR.

THE APPENDIX: ITS USE, ABUSE, CLAIMS FOR PROTECTION. ABUSE, AND ITS

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—As soon as I saw in the daily Press a reference to my recently read but not fully published paper on the appendix, I consulted a friend holding one of the very highest positions in the surgical profession. first advice was, "Do nothing." I agreed with I agreed with him; but, at the same time, I pointed out that twenty times as many medical men would form their idea of my paper from the brief but misleading notice in the lay Press as would read my paper itself. And now we have a surgical teacher so universally esteemed as Professor William Rose, in criticising my views, actually stating that his knowledge of them is gained from the Daily Mail! But the remarkable thing is that, not only Professor Rose, but other surgeons who have been content to get their information on the subject from the newspapers, have not been careful to read even them correctly. I never suggested that "the appendix should be detached in certain cases" "to wander at will through the intricacies of the general peritoneal cavity"—quite the contrary.

With much that Mr. Rose says I agree—e.g., that

"we never hear in the lay Press of the failure of" remedies and manipulations. I felt strongly the omission of the lay Press to state that my surgical brethren were to a great extent not in agreement with me—that, in fact, the question was still *sub judice*. However, the *Pall Mall Gazette* did something to redress that by printing an abstract of the discussion on the paper. Professor Rose concludes with a most apt quotation from Sir William Jenner:—"It is the duty of the physician (including, of course, the operating surgeon and the general practitioner) to prevent disease," "and, failing that, to alleviate suffering and prolong life."

It is with the object of preventing one of the most terrible diseases known—septic peritonitis—that I advo-cate the transference, in selected cases, of the appendix from the peritoneal cavity to the abdominal wall. My published cases show what this can do to "alleviate

suffering," and there is even a possibility, having regard to Metchnikoff's well-known views, that it may tend to

prolong life."

It is evident also that your correspondent, "M.B., M.S." (MED. PRESS, Jan. 20th, 1909, p. 67), has also not read my paper, or even Sir William Macewen's address on the functions of the appendix, or other before making up his mind about the questions under discussion. When the appendix is properly transplanted into the abdominal wall, and any stricture, twist or kink of its proximal part removed, the result is not to "allow permanent escape of its lubricating secretions." Surgeons do have to cut down on the appendix in cases where they cannot make themselves "as certain as possible that pathological changes calling for its removal exist." And it is quite misleading to say that, "If the appendix on exposure should be found healthy, it would be left intact; if diseased, it would be removed." Hundreds of really or apparently intact appendices have been removed by surgeons even of high reputation for experience, character, and judgment. No one can be more reluctant than I to remove an appendix which is apparently healthy; but there are diseases of the appendix which only the microscope can reveal, and there are cases in which, while the appendix looks healthy, the history tells the surgeon that it has been diseased before, and may be diseased again. When in this dilemma, I have felt the greatest comfort from being able to preserve the appendix, and at the same time to transfer it to a place in the abdominal wall, where an attack of appendicitis will not be attended by the dangers of peritonitis. "M.B., M.S." is right in agreeing with you that "we

must free our minds from cant in regarding that great institution, the British Press." But that does not mean that we are to scold it. The journalist who first set alight the flame of publicity as regards appendicostomy in the lay Press went to the West London Hospital for information. The Secretary telephoned to me, and I, of course, had to reply that I could not give him any information. He then appears to have applied to some other medical man—I do not know whom—who was, perhaps, as good-natured as my friend Professor was, pernaps, as good-natured as my friend Professor William Rose, and equally vague in his ideas about appendicostomy. It was not the fault of the lay Press that their first references to my paper were so misleading (so particularly trying to me, I may add, because they represented my views as being the exact opposite of what they really were). As soon as my paper appeared in full, the lay papers corrected the worst mistakes which they had formerly made.

The following questions arise (if we are really going

The following questions arise (if we are really going to "divest our minds of cant"):-

(1) Is the public, or a large segment of it, interested in the progress of medicine?

(2) If it is, can any power on earth prevent the newspapers from endeavouring to keep it informed on such matters?

(3) Then what steps can medical men, or medical institutions (including the medical journals) take to ensure that medical paragraphs and articles in the lay Press shall be accurate, shall distinguish between what is controversial and what is accepted, and shall prevent the publication of living medical men's names?

I offer no answer to these questions myself—at all events just now. What I am concerned with is to persuade your subscribers to read my paper itself, and, above all, the 36 case reports which form the real substance of it. The theories and hypotheses to which my critics have almost entirely confined their attention were mostly put forward by me long ago, in the Cavendish Lecture for 1907 and elsewhere.

I am, Sir, yours truly,

C. B. KEETLEY.

Grosvenor Street, January 20th, 1909.

A FORGOTTEN PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—We are informed by posters large, that, thanks to a Liberal Government, old-age pensions were paid on January 1st, 1909. I am no politician, but it appears to me that this poster should rather read: "Thanks to the self-denial of the middle classes, who have always to pay the piper, but who are never

allowed to choose the tune." We have in power at the present time a Government, numerically strong, but some of us are inclined to think mentally weak. The one object of this Government is to diminish the hours of labour and to increase the pay. Through an hours of labour and to increase the pay. Inrough an oversight, doubtless, the most sweated and worst paid profession has escaped the vigilant eye of our legislators, and in order that the Government may not be blamed for this inadvertent omission I would draw the attention of your readers to several points which might interest their local M.P.s.

1. Midwives Act.-Provision made for the patient obtaining the services of a medical man in case of difficulty. No provision made for paying his fee.

2. Birth Notification Act.—The duty of notification in certain cases falls upon the medical attendant. No fee; but a fine in the event of the medical man failing

3. Medical Inspection of School Children.--Provision made for ascertaining mental and physical defects. No provision made for remedying them. If such children go to a local hospital, sweating of the hospital staff is the result.

4. Death Certificates.-No fee.

· I am, Sir, yours truly,
A Provincial Practitioner.

Bedford, January 22nd, 1909.

THE INEBRIATES' ACTS COMMITTEE AND DRUG CURES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—It seems to me a matter for regret that the Committee whose Report you have just examined in two able leaders did not find it possible to deal in plain terms with the question of quack drug cures. An enormous service to the public would have been done merely by publication of analyses of the medicines employed in the most bepuffed of these cures. Some of them contain no ingredient of any potency whatever; a good many, especially those hailing from the United States, contain nothing but alcohol. Authoritative publication of such facts would alone have struck a heavy blow at a great system of injurious imposture, and would, perhaps, have induced innocent lay supporters of some of the cures now carried on under the cloak of philanthropy to consider their position and to listen to reason. As it is, the curt, ambiguous, or even equivocal terms in which the Committee dismiss the subject, are calculated to confirm the opinion of the uninitiated that there is "something in" the claims to miracle working which are put forth by most of the proprietors of drug cures. It should surely be possible to prove, even to people totally ignorant of science, if commonly intelligent, that alcoholism is not a simple condition due to one and the same cause, that its causation is extremely complex, being made up of various distinct physical, mental and moral causes. In one case, merely mental or physical depression may have led the patient to find a solace in drink, or he may have been led on through trust in one of the sham tonics containing alcohol, now so enormously advertised. In another case the cause may be moral obliquity developing from childhood, a condition where example and habit have produced a low character, in which alcohol to excess affords the sole enjoyment in life. There is then the hardened sot, whose brain and nervous system have undergone alcoholic degenerative changes, with actual destruction of tissue elements, changes always accompanied by corresponding loss of will power and in-ability to resist the temptation to drink. To cure alcoholism in any of its numberless phases merely by the administration of drugs would constitute a miracle something like the exorcising of a demon of the olden days. The pretence at secrecy in most of these cures is alone enough to condemn them. The discoverer of a simple remedy for drunkenness would rank with the greatest benefactors of mankind, with Jenner, Pasteur. Lister. Wealth and fame would surely be his. All be would need to do would be to demonstrate the quality of his remedies before a competent scientific tribunal. That the pretences of unqualified drink doctors are accepted by large numbers of "educated" men is not wonderful when we recollect that "educa-tion" in our great schools and colleges virtually

excludes science, and often actually leads the "cultivated" graduate to distrust, scorn, or hate science and the scientific method. This is one of the factors helping to lead our country to disaster in matters of more vital importance than bogus drink cures; and so the pessimist may ask—why trouble about so trivial a detail as the saving from destruction of a few more or less among the masses of an already degenerate and falling people?

I am, Sir, yours truly,
MEDICAL TEMPERANCE REFORMER. January 21st, 1909.

#### THE SCOTCH OATH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—As you say in an editorial note in your last issue, judges, magistrates, and coroners are uniting in an effort to induce witnesses to swear according to the Scottish fashion, instead of as was formerly the case uniting to brow-beat the unfortunate wight who elected to use his legal privilege of doing so. This being so, it seems to me as if the time was propitious for all bodies interested in preventive sanitation to follow the legal example and endeavour to diffuse a knowledge of the dangers of the present insanitary practice. It is common at the present time to place in public dis-pensaries, and such places, large notices calling attention to the dangers of spitting, and to the simple measures which can be taken to prevent the spread of tuberculosis. I venture to suggest that bodies, such as the Sanitary Association and the Women's Health League in Dublin, and kindred bodies throughout the United Kingdom, should endeavour to obtain permission to place posters in all the Courts calling attention to the dangers of "kissing the book" and advising witnesses to adopt the Scotch oath. I am sure the legal authorities would facilitate the exhibition of the poster, and, if it was systematically exhibited for some six months it would do more to stop the present practice than any amount of occasional advice. It is obviously impossible for a judge to warn every witness specifically of the danger he or she is running by kissing the book, but by allowing the posting of a large notice in his court the same end would be even more successfully attained.

I am, Sir, yours truly A MEDICAL WITNESS.

January 23rd, 1909.

THE STANDARDISING OF DISINFECTANTS. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Absence abroad has till now prevented my noticing the combined attack of three trade rivals which has been appearing in the columns of various medical and sanitary journals during the past two or three weeks, professedly arising out of the suggestion recently put forward by Dr. Rideal and myself in connection with the test introduced by us five years agoa suggestion which, I hasten to add, was made at the earnest request of certain prominent Medical Officers of Health, with the object of calling attention to the need for standardising, a condition which is now imposed in the "tender forms" of many of the leading

authorities dealing with the question of subsidence.

Jeyes' Sanitary Compounds Company have already, in the above-mentioned columns, expressed their readiness to adopt any better test that may be produced than that above referred to, so I may for the present dismiss that point. But I do protest against the introduction of personalities and deliberate attempts to distort facts.

It is within the knowledge of these correspondents that the Rideal-Walker test was published two years before I was appointed managing director of Jeyes' Sanitary Compounds Company, and vet again and again my present position is harped upon in order to suggest that the test was devised to suit, and unfairly favour, Messrs. Jeyes' preparations. The intention is obvious

A glaring example of the other method I complain of may be seen in Mr. Kingzett's letter in your issue of December 23rd, 1908. There, choosing to ignore the modification introduced by Dr. Sommerville and myself (a) to meet such cases as may call for the use of

special diluents, he calmly compares the effect of a preparation of his own in the presence of sea water with that produced by one of my company's prepara-tions (also in sea water), the labels of which state that "the fluid will not mix with brackish or sea water," suppressing the fact that where such conditions exist we put forward a special preparation made to meet this particular requirement, and bearing a label to this effect. This fact is well-known to Mr. Kingzett, and, though one may grow accustomed to encountering such manipulations in trade circulars, it argues both great confidence and a curious idea of your readers' know-ledge and common-sense to use your columns for similar methods. As is well-known to Mr. Kingzett, the original test did not seek to embody any special conditions, but simply compared the relative value of various disinfectants in pure water; the modifications have followed, naturally and necessarily, in the effort to meet particular and varying requirements, and are intended for use only at the call of the consumer.

As to his parting sneer at the idea of allowing a mixture of emulsified disinfectant with water to stand

24 hours before use, I will not be so unjust as to credit him with a quarter of a century's ignorance of a

common hospital practice.

In conclusion, Sir, I desire to say that the test and its modifications represent honest attempts to grapple with a serious and difficult problem in a scientific manner, in the interest of the consumer, first of all, and next, not in that of one firm only, as has been insinuated, but of all manufacturers who have the same interest at heart. The fact that a large number of rival preparations, including some manufactured by the three firms referred to, already conform to the conditions proposed, might have suggested even to them that the object we had in view has been achieved. I am, Sir, yours truly,

J. T. AINSLIE WALKER.
Jeyes' Sanitary Compounds Company, Limited,
64, Cannon Street, London, E.C., January 18th, 1909.

### A DISCLAIMER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—At the request of the Stratford Branch of the British Medical Association, some few weeks ago I read a paper entitled "Medical Evidence and the Laws Relating to Compensation for Personal Injury. short time afterwards the editor of a medical journal wrote asking permission to publish the paper, and I

In the article I took occasion to deprecate the increasing prostitution of medical evidence, which, as you are aware, is confined to an infinitesimally small proportion of the profession.

I have been greatly annoyed to see in the daily press certain isolated quotations from my article, which without the context are calculated to give a wholly unfair view of the position.

The object of this letter is to state that I have taken no part in the publicity given to the article, nor was it done with my sanction, and that—while I am anxious that those who lay themselves open to the charge of unfair dealing should be exposed—the lay Press is, under no circumstances, the medium that I should have voluntarily chosen for this purpose.

I have communicated with the Office of the journal concerned, and am assured it has in no way been in

communication with the lay press.

The address, which was delivered in the East End, was favourably received by members of the profession present.

I am, Sir, yours truly, R. J. COLLIE.

Porchester Terrace, 19th January, 1909.

At the last quarterly meeting of the Council of the Royal College of Surgeons on January 14th, Mr. Henry Morris, President, in the chair, a formula for a new by-law relating to the admission of women to the examinations for the diplomas of Fellowship and membership, and of the License in Dental Surgery, was submitted.

### SPECIAL ARTICLES.

IRISH AND SCOTCH ASSOCIATIONS AND HOSPITAL APPOINTMENTS.

On the 21st inst. a conjoint meeting of the Irish Schools and Graduates and the Scottish Medical Diplomates' Associations was held at the Hotel Cecil, at four p.m. The object was to consider the exclusion of candidates not holding the higher diploma of two favoured English Colleges from most of the London and many of the provincial hospital posts. Sir Charles ball took the chair. The first resolution was proposed by Dr. Macnaughton-Jones, seconded by Dr. Horne, President of the Royal College of Physicians of Ireland, and carried unanimously. It ran: "That the present exclusion of all persons who do not hold certain qualifications from candidature for honorary positions on the staff of a public hospital is contrary to the public weal, and is a restriction which is not to the interest of the institution itself, excluding as it does all other candidates who may have exceptional claims to fill such positions." The second resolution, to the effect "That the advertisements in the columns of the lay press that honorary offices in certain hospitals are open only to those holding the Diplomas of some particular Corporation gives to the public the impression that such restrictive regulation is justified by the exceptional character of such qualification, which is not in accordance with fact." This was prowhich is not in accordance with fact." This was proposed by Dr. David Walsh, seconded by Dr. McManus, and carried unanimously. Mr. Lentaigne, President of the Royal College of Surgeons of Ireland, Surgeon-General Sir Thomas Gallwey, C.B., Sir Charles Cuffe, K.C.B., Dr. J. J. McCann and others supported the resolution. Among those present were: Mr. P. J. Freyer, Drs. G. Vere Benson, Fitzgerald Powell, J. G. Fitzgerald, Percy Lewis, A. Harries, G. N. Macnaughton, McMunn, Campbell Boyd, G. W. Dawson, Sydney Stephenson, R. J. Young, and others.

In the evening a dinner was held at the Hotel Cecil. Guests were received by Sir Charles Cuffe, K.C.B., President of the Irish, and by Dr. David Walsh, President of the Scotch Associations. Among the guests were: Sir Charles Ball, Mr. Lentaigne, Dr. Horne, Mr. S. G. Kirkby Gomes, Dr. Mouillot, Ccl. W. H. Thornhill, Col. James Moorhead, Mr. Swinford Ed-

Thorrhill, Col. James Moorhead, Mr. Swinford Edwards, Dr. Phineas Abraham, Dr. Creasey, and others, some of whose names have been mentioned above as present at the afternoon meeting. Professor J. Glaister, President of the Faculty of Physicians and Surgeons of Glasgow, was unfortunately prevented at the last moment from attending the meetings. At the close of the dinner a hearty vote of thanks was accorded to the Hon. Secretaries, Drs. T. Hobbs Crampton and P. H. Parsons, for the great personal labour and enthusiasm which had been thrown into the organisation of the

conjoint movement.

### REVIEWS OF BOOKS.

ANATOMY OF THE BRAIN AND SPINAL CORD. (a)

This voluminous and elaborate guide to the anatomy of the nervous system must surely rank as "high water mark" in monographs. It is intended both for students and practitioners, though it will probably be more resorted to by the former than by the latter. The illustrations, close upon 130 in number, 33 being printed in colours, have been drawn with the greatest care and really go far to elucidate the text.

The subject matter is presented in the order that it comes under the observation of the dissector, and, when necessary, explanatory embryological data are given to assist the student to understand the adult One special object in the work has been the location of functional centres and the tracing of their apparent, associative and efferent connections, so that throughout function goes hand-in-hand with structure.

The nomenclature is that of the B.N.A., but the English equivalents of the Latin terms have been largely employed.

(a) "Anatomy of the Brain and Spinal Cord." By Harris E. Lantee, M.D. Ph.D., Professor of Anatomy, University of Illinois and Jenner Medical College, Chicago. Fourth Edition. London: Sidney Appleton. 1908.

### RECENT MEDICAL LITERATURE. Summary OF ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

Treatment of Syphilis at Rochester Row Military Hospital.—Captain Hayes (R.A.M.C. Journ., January, 1909) gives a synopsis of the method of treatment of this disease as carried out at the Rochester Row Hospital. The treatment by intramuscular injections is considered best adapted to the needs of the service. Either calomel or metallic mercury injections are usually used, the preparations being those known as Lambkin's creams. The following is given as a general guidance for these injections: -Six weekly injections; four of calomel, agr. in each injection, and two of metallic mercury, i gr. in each injection. Two months' rest, and to attend fortnightly for inspection. Four fortnightly injections; amount of metallic mercury, 4 gr.. Four months' rest, and to attend as before. Four fortnightly injections; amount of metallic mercury, 4 gr. Four months' rest, and to attend as before. Four fortnightly injections; amount of metallic mercury, 4 gr. Six months' rest, and to attend as before. Four fortnightly injections, amount of metallic met-cury, 4 gr. Total length of treatment two years. In a great number of cases active symptoms have disappeared by the third calomel injection, when metallic mercury is substituted. The following instructions are issued to all concerned in the treatment of the case, and to the patient himself:—"(1) Weight to be taken weekly and to be recorded on the case sheet. (2) Urine to be tested weekly and record taken. (3) Teeth to be brushed after each meal, tooth-powder being supplied free to each patient. (4) The mouth-wash supplied to each patient to be used frequently. Two mouth-washes are used in this hospital, one a combination of lead acetate and alum sulphate, and the other a simple potassium chlorate solution. (5) Each patient to spend as much time in the open air as exigencies of the ward routine permit. (6) Each patient is to take a hot-air bath at least every second day, in which he will remain not longer than five minutes; the baths are only to be taken under the personal supervision of the wardmaster or his representative." Each case is carefully watched, and if it does not respond to one kind of injection another is tried. Calomel injections give the best result in the early symptoms of the disease. Soamin is excellent where there is much ulceration of the mucous membranes, and in cases with condylomata. Arsacetin is similar in action to soamin, but appears particularly useful in clearing up early skin lesions. It has the great advantage that it need not be prepared fresh daily as must be done with soamin.

Magnesium Sulphate in the Treatmont of Tetanus .-Miller (Amer. Journ. Med. Sciences, December, 1908) records a successful case of the treatment of acute tetanus by subarachnoid injections of magnesium sulphate. In all, ten injections were given, 2.5 cc. of a 25 per cent. solution of magnesium sulphate were injected into the spinal canal by means of a lumbar puncture. After each injection there followed promptly a paralysis of the legs, abdominal walls, sometimes the arms, while the neck and masseters usually escaped, and the muscles of the face practically always escaped. This paralysis appeared within thirty to sixty minutes, and varied in duration from eighteen to twenty-nine hours. Retention of urine was the rule, and it was necessary to catheterise the patient for nine days. No purgative effect was noted from the magnesium absorbed. The chief danger in the use of intraspinal injections of magnesium lies in its direct depressing influence upon the respiratory centre, this effect was produced repeatedly. The first injection produced no apparent effect upon respiration, nor did the third, which consisted of a smaller dose and of less concen-

tration than usual (2 cc. of a 16.6 per cent. solution), and was thus possibly too small to affect the respiratory centre. After each of the other injections, however, there was a more or less marked drop in respiratory rate, which was accompanied by a decrease and irregularity of amplitude; this change was of eleven to fourteen hours' duration, and in some instances alarming, notably after the second and fourth injections, when the rate dropped to seven and five per minute respectively, and necessitated constant watching and preparation for immediate artificial respiration. In spite of this respiratory collapse the circulation remained in good condition, there was no cyanosis, and the pulse remained regular and steady throughout. Miller gives the record of fourteen cases of tetanus treated by magnesium sulphate. Of eleven cases treated by subarachnoid injections five recovered, a mortality of 55 per cent.

Malignant Disease of the Ovary.-Gardner and McCleary (Surg., Gyn., and Obst., December, 1908) report eight cases of malignant disease of the ovaries. They remark that malignant tumours of the ovary are not only common, but they are of great variety. The relative percentage of malignant tumours to all tumours of the ovary has been variously estimated by different observers. Kelly puts it as low as 8 per cent., Leopold as high as 23 per cent., and Werder at 25.3 per cent. Of the eight cases recorded here, one was hypernephroma, one endothelioma, two carcinomata originating in adenocystomata, one carcinoma originating in papillocystoma, one adenocarcinoma, probably metastatic, and two varieties of sarcoma. The case regarded as metastatic was regarded as such apparently because the disease was bilateral, and Bland-Sutton has stated that bilateral carcinoma is secondary. In the present case no primary focus was discovered, and we find no valid reason in the account given for regarding the case as other than primary carcinoma.

Appendicitis and Leucocytosis.-Mitchell (Brit. Med. Journ., January, 1909) publishes a record of personal experience of the relation of leucocytosis to appendi-He found that in practically all cases of appendicitis and of acute abdominal or pelvic inflammation going on to pus formation or necrosis, there was an increase in the number of leucocytes. Speaking generally, the greater the increase the more scarce the lesion and the graver the prognosis. An exception to this was found in severe cases of sudden onset, in an individual whose powers of resistance were slight. It was more important to know the rate at which the leucocytosis was increasing than to know the actual count of leucocytes. A differential count was even more instructive than an absolute count. The noticeable change was an increase in the number of polynuclears, with a relative decrease of lymphocytes and eosinophils.

Alto-frequent Cytolysis of Cancer.-Under this title, Dr. J. Rivière, of Paris, has published (Annales d'Electrobiologie et de Radiologie) a critical study following up his communication on the same subject to the International Congress of Medical Electrology and Radiology, Paris. In his former communication, Dr. Rivière spoke of the cytolytic action of high frequency sparks on the cancerous cell, and of the necessity of employing these same sparks and effluves in the raw strgical wounds (brèches-opératoires) of malignant tumours, to disinfect and drain them, in order to prevent recurrence. He added that this special mode of application of electricity appeared to be, at the moment, one of the only therapeutical means to be tried in cases of inoperable tumours. The word "ful-

guration," since given to this method, has established an uncertainty as to the method and its author. In his work Dr. Rivière shows that the "blowing off air or carbonic acid-which has been added to his method -is absolutely useless, and that this is the cause of the burn produced by the spark in its contact with the tissues; he adds that the electrode commonly employed is defective, because it is traversed in its whole length by the conducting wire, which provokes short circuit in the operator's hand. The electrode employed by the "father" of the method only receives the current in the active part. With reference to the curette, Dr. Rivière considers that its use is detrimental rather than useful, and that it is preferable to have several séances of alto-frequent scintillation, in order to continue the elimination of the morbid or contaminated cells. As for the modus operandi, Dr. Rivière repeats the formula which he gave in his address to the Congress of Rome: "The voltage and intensity of the sparks and effluves varies with the pathologic equation of the patient; this mode is before all a question of appreciation for the electrotherapeutist and the surgeon.'

### **OBITUARY.**

JOHN HOLDEN WEBB, M.R.C.S., L.R.C.P., of Melbourne.

WE regret to record the death of Mr. John Holden Webb, one of the best-known Melbourne surgeons, on December 10th. We take the following from The Age. Melbourne:—"Upon his arrival in Victoria some thirtysix years ago, Mr. Webb was appointed Resident Surgeon to the Amherst Hospital, and afterwards to a similar position at Creswick, where he remained for several years. Subsequently he settled in Melbourne, and rapidly acquired a reputation and enjoyed an extensive practice as a surgeon. For many years he was one of the surgeons to out-patients at the Mel-bourne Hospital, and was also Acting Lecturer on Surgery at the Melbourne University. He also filled the position of Honorary Librarian to the Medical Society of Victoria. Of late years Mr. Webb devoted himself almost exclusively to the study of cancer. In the treatment of this disease he met with considerable success, and has done much important original work in this connection. He was always a profound student, and one of the best read members of his profession." The name of Webb will always be associated with a cholesterinic theory of cancer, and treatment by sodium oleate injections and internal adminisment by sometime of purified ox gall, which readers of The MEDICAL PRESS AND CIRCULAR will be familiar with. in the writings of Dr. J. A. Shaw-Mackenzie in our columns.

DR. GEORGE DICKSON, OF EDINBURGH.

DR. DICKSON died in Edinburgh on January 18th, in his 71st year. He died in harness, and was doing his usual work up till a week before his death, when symptoms of cerebral hæmorrhage set in, and though he rallied temporarily, a renewed hæmorrhage proved fatal. Dr. Dickson was a well-known and much respected practitioner, his kindliness and courtesy made him esteemed by all who knew him. He was one of the most prominent Scottish Freemasons, and had been connected with the Lodge of St. Mary's Chapel. No. I., for 40 years, and for 5 years, from 1891, he was Right Worshipful Master. At the time of his death he was Librarian and Historian of the Lodge (of which he had edited a history), and he devoted much care to the old minutes, which are in existence from July, 1599. He was a leading member of the Grand Committee of Grand Lodge, and was an honorary member of nearly every Lodge in the district. He was Secretary of the Lodge when the King (then Prince of Wales) was made a member. At the celebration of the targentangue of the Lodge in 1892. Dr tion of the tercentenary of the Lodge in 1899, Dr. Dickson was presented by his brother Masons with his bust in token of their appreciation of his services. Dr. Dickson is survived by a widow and grown-up family. His only son is a medical man, and is the Lecturer on Bacteriology in the University of Edinburgh.

### MEDICAL NEWS IN BRIEF.

The Dublin Branch of the Research Defence Society.

A MEETING to inaugurate a Dublin branch of the Research Defence Society will be held in the theatre of the Royal Dublin Society (by kind permission of the Council) on Wednesday, to-day, January 27th, at 5 p.m. The chair will be taken by Sir John G. Nutting, Bart., D.L. The speakers will be: The Very Rev. the Dean of St. Patrick's; Count Plunkett; Dr. Burne Prog. Pay. Coll Phys. the Right Hon T. W. Horne, Pres. Roy. Coll. Phys.; the Right Hon. T. W. Russell, M.P.; Mr. Stephen Paget, F.R.C.S.Eng., Hon. Secretary of the Society; Rev. Thomas A. Finlay, S.J., F.R.U.I.; and Mr. Alexander Blood, K.C. It is hoped that there will be a very full attendance of members of the medical profession and of their friends.

Action by a Medical Man for Libel.

AT Ipswich, on Friday and Saturday last, the case f "Macleod v. Mullock and Another" was tried. Mr. F. E. Smith, for the plaintiff, said that this was an action for libel. The plaintiff, a medical practian action for libel. The plaintiff, a medical practi-tioner, came, in March, 1907, to settle in Southwold, where the two defendants, Dr. Mullock and Dr. Tripp, were already in practice. In May, 1908, Dr. Mullock, acting on his own behalf and on that of Dr. Tripp, wrote to Dr. Tyson, the honorary secretary of the local division of the British Medical Association, of which the defendants, and not the plaintiff, were members, making certain specific charges of "touting" and other serious breaches of professional etiquette, and asking for the advice of the Divisional Ethical Committee on the matter. Dr. Tyson, having consulted his committee, and having received a telephonic communication from the defendants leaving the matter in his hands, communicated by letter with the plaintiff, specifically indicating the charges which the defendants had made against him, and offering the arbitrament of the British Medical Association should he desire to offer any explanation. The plaintiff, in answer, wrote refuting the various charges made, and expressing a hope that the influence of the Association might result in a retractation and apology by the defendants, though he did not admit its authority to decide such a serious ne did not admit its authority to decide such a serious matter. No apology being forthcoming, these proceedings were commenced. The defendants pleaded that the occasion was a privileged one. It further appeared that Dr. Mullock had, in a letter to the Secretary of the Medical Defence Union, repeated from hearsay other serious charges against the plaintiff for which there was no foundation whatever.

Evidence by the plaintiff and other witnesses in support of the opening having been given, Mr. Hohler submitted that the occasion was privileged, whereupon Mr. F. E. Smith said he was quite satisfied to treat the occasion as privileged and to submit the question

of malice to the jury.

The defendants both gave evidence, and said that they felt justified on the facts before them in going to the British Medical Association for advice, and that they did not expect Dr. Tyson to communicate with the plaintiff. They denied the existence of any malice towards the plaintiff. They still believed the charges made to be true, but had not justified on the advice of their solicitor, there not being sufficient legal proof of the facts alleged.

The jury returned a verdict for the plaintiff with £300 damages.

Death from Hæmophilia.

On January 14th a boy of 16, named Edgar Thomas, of Sheffield, received a slight injury to the inside of his left cheek, inflicted with the broken end of a glass syringe whilst playing with another youth. Bleeding commenced, and continued intermittently, the boy dying six days later.
Mr. J. Kenyon Parker, Deputy-Coroner, held the

inquest at the mortuary.

The mother of deceased, Annie Elizabeth Thomas, said she took the boy several times to the infirmary. Previously, when he had had cuts or scratches, he had bled for hours, and in some instances a day or two. She had two younger sons, both similarly affected.

J. A. Broomfield said he and deceased were playing

with the glass syringe produced, which was broken at the end, before the accident. He was going to squirt when deceased ducked his head and the syringe caught him in the mouth, making it bleed.

Dr. Leonard Daft said the cause of death was exhaustion after hæmorrhage from the wound in the mouth. The boy suffered from a disease called hæmo-Anyone so afflicted might bleed for hours or philia. days from a slight cut. The disease was rare, and ran in families generation after generation. They had had the boy time after time in the infirmary for bleeding and infusions of blood in his knee-joints. It was not necessary, even, that there should be a wound in these cases. Bleeding sometimes started spon-

The Coroner remarked that he did not think Broomfield could be blamed, and the jury returned a verdict of "Accidental death."

#### Barber's Rash.

BEFORE Sir G. Sherston Baker, at Gainsborough County Court, on January 20th, W. R. Randon, brick-

layer, claimed £7 7s. from Horace Francis, hairdresser. Plaintiff's case was that he was shaved twice a week by defendant until October oth. On the latter date he complained of the razor "dragging," and defendant stropped it again before he finished shaving him. On the following day he felt the lower part of his cheek pain him, and nine or ten days later, a rash having appeared, he went to Dr. Passmore, who told him that he was suffering from barber's rash. Defendant did not use fresh towels for every customer.

His Honour: How much does he charge?

Defendant: A penny a time.

Dr. Passmore gave evidence, and, being cross-examined by Mr. Tweed, said that barber's rash was caused by contagion, and was set up by a microbe. The plunging of a razor into hot water before use would not remove the risk of contagion or kill the microbe.

For the defence it was submitted that reasonable care was exercised by defendant, who said he had been in business three years, and had never had a complaint. He used an antiseptic soap manufactured in Sheffield, and always plunged his razors into hot water before use. Cross-examined by Mr. Southron, he said that he shaved about 350 a week, and used from 20 to

30 towels.

His Honour again said that not much could be expected for a penny, but thought that plaintiff had proved his case, and gave a verdict for £4 with costs.

### The Gresham Lectures.

DR. F. M. SANDWITH, Gresham Professor of Physic, will deliver a course of four lectures on February 9th. roth, 11th, and 12th, at Gresham College, Basinghall Street, the subject being "The Results of Recent Research on Certain Diseases," and "The Life Work of Pasteur." The lectures are delivered at 6 o'clook each evening.

### Royal Society of Arts-The Swiney Prize.

A MEETING of the adjudicators of the Swiney Prize was held at the Royal Society of Arts on Wednesday last, when, on the motion of the Lord Chief Justice, seconded by Sir R. Douglas Powell, K.C.V.O. (ex-President of the Royal College of Physicians, London),

work, "Criminal Responsibility."

Dr. Swiney, who died in 1844, bequeathed the sum of £5,000 in Consols to the Society of Arts for the purpose of presenting a prize on every fifth anniversary of his death to the author of the best published work on Jurisprudence. The prize is a cup of the value of on jurisprudence. The prize is a cup of the value of floo, and money to the same amount, and the award is made jointly by the Royal Society of Arts and the Royal College of Physicians. The cup now given is made by Messrs. R. and S. Garrard and Co., after a design specially prepared for the first award by D.

### Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of this Society was held on the 15th inst., Dr. de Havilland Hall in the chair. In accordance

with their custom for many years past, the Committee devoted the bulk of their time at the first meeting of the year to the examination of special reports on the cases of those members who seem to be unlikely to be ever able to resume professional work. One of the special features of the Society is the practically permanent provision made for those members who appear to be chronically afflicted. When the Society was first started, although this plan was determined upon, and a considerable outlay in respect of it foreseen, yet, as the years have gone by, the number of these chronic cases has increased more quickly than was anticipated, and now, numbering over 40, they require an out-go exceeding £3,000 per annum.

Proposed Medical Library Association.

AT a meeting of those interested in medical libraries. held at Leeds on the 9th inst., it was decided unanimously to form an Association of Medical Libraries, and a provisional committee was appointed to draw up the constitution and rules. Professor Osler up the constitution and rules. Professor Osler (Oxford) was invited to become the first President; and Professor Walker Hall (Bristol) and Mr. Cuthbert E A. Clayton (Librarian, Manchester Medical Society) were asked to undertake the duties of temporary Secretical Control of the Control of t The following are some af the objects of the Association: -(1) Intercourse of those interested in medical library work and the discussion of matters associated with the fostering and care of libraries.

(2) Diffusion of information as to the branches of medical literature specially catered for at different centres, and as to the value of the various books and new periodicals which are issued from time to time.
(3) The promotion of measures whereby a larger number of practitioners in each centre may be induced to utilise the library facilities of each district. (4) The consideration of matters connected with the present rapid increase of periodicals, publication of books, etc. (5) The opening up of better chances of advancement for library assistants. By such means there would be an inducement to parents to put their sons to such an occupation, and the librarians would be able to have better material for training (6) The archange of better material for training. (6) The exchange of duplicate books and periodicals. When the Association is in working order, it is hoped that a certain number of the libraries interested will join together to form a circle for the loan of their research and other literature.

Sleeping Sickness in the Belgian Congo.

SERIOUS study is being devoted by the Belgian Colonial Ministry to the subject of the sleeping sickness. With a view to combating it more effectively, M. Renkin, the Colonial Minister, has just provided for the establishment of six new hospitals for the treatment of patients suffering from the disease. These will be placed under the direction of doctors who have followed a special course at the School of Tropical Medicine at Brussels prior to their departure for the Congo. Credits are spoken of as likely to be demanded for the purpose of reinforcing the medical corps in the Colony.

Society of Apothecaries of London.

The following candidates, having passed the necessary examination, have received the L.S.A. Diploma of the Society, entitling them to practise Medicine, Surgery, and Midwifery:—G. K. Aubrey, J. J. S. Rowe, J. B. Tackaberry, H. B. Waller, and H. V. White.

Royal College of Surgeons in Ireland.

THE Annual College Dinner will take place on Saturday, February 20th, at 8 p.m. precisely. His Excellency the Lord Lieutenant has graciously accepted the invitation of the President and Fellows to be present at the dinner.

THE issue of the well-known guide to the "London Charities," by Herbert Fry, reminds us of the lapse of another year. Those who are interested in the administration of our medical charities will find within the familiar red covers of this little book an interesting mass of information. The price is eighteenpence, and the book is issued in the excellent style of Messrs. Chatto and Windus.

### **NOTICES TO** CORRESPONDENTS.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule. SUBSCRIPTIONS.

SUBSCRIPTIONS.

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insertion; 6d. per line beyond.

DR. W. M.—The only way we know of getting a copy of the Acts in question is to write to Messrs. Wyman and Co., of Fetter Lane, London, E.C. Official copies of Government papers are not always sent to the editors of medical journals, even when the matter dealt with is of obvious medical interest and importunce. A. HENDERSON.—There are many medical missionaries in China, as well as a large number of lay fellow-workers. For the next few years the country is likely to be in an unsettled condition, and, frankly, we should not advise you to go thither on such a mission.

a mission.

#### BRITISH r. CONTINENTAL HEALTH RESORTS.

BRITISH r. CONTINENTAL HEALTH RESORTS.

A correspondent draws attention to the "exaggerated statements which are so common when discussing the merits of a place in regard to invalids, and when there are interested motives sometimes for extolling the characters of such places." He remarks that visitors have this winter been "tempted by the advice of well meaning, but mendacious friends, and equally mendacious and flamboyant advertisements, to try 'Our Own Riviers.' To some extent the misrepresentations referred to are due to the ignorance and self-interests of members of our profession, which should be discouraged."

Certifting Surgeon.—The number of cases of poisoning and of anthrax reported to the Home Office under the Factory and Workshops Act during November, 1998, was 49, consisting of 46 cases of lead noisoning, and one each of mercurial poisoning, arsenic poisoning, and anthrax. In addition 25 cases of lead poisoning (3 of which were fatal) were reported during November among house painters and plumbers During the eleven months ended November, 1908, the total number of cases of posoning and of anthrax was 682, as compared with 592 in 1907. The number of deaths during the same period was 39, as against 38 in 1907. In addition there were 214 cases of lead poisoning (including 36 deaths) among house painters and plumbers during the first eleven months of 1908, as compared with 158 cases (including 34 deaths) during the same period of 1907.

EXPERIMENTS ON PATIENTS.

### EXPERIMENTS ON PATIENTS.

### To the Editor of THE MEDICAL PRESS AND CIRCULAR.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—I am afraid your correspondent, Mr. Sers, has never quite mastered the meaning of "analogy"? A hospital can control its operations and treatment. It would, however, be rather difficult (and very risky) for a boarding-house keeper to guarantee that there were not, and never would be, any thieves among the household from cellars to garret! Indeed, it is a question whether, if a case of a thief being there after all occurred, there might not be liability for restitution or compensation! Such are the illogical arguments, the spurious "analogies," and plausible missues of terms which arise, no doubt often from ignorance; but which often mislead on equally ignorant portion of the public.

I am, Sir, yours truly.

I am, Sir, yours truly, GEORGE W. F. ROBBINS.

Tr Quoque (Aberdeen).—The resident medical appointments in the London hospitals, apart from those hospitals with medical schools attached, are quite open; but personal interest with members of the staff is not without value in the selection of a

### Meetings of the Societies, Tectures, &c.

WEDNESDAY, JANUARY 27TH.

ROTAL SOCIETI OF ARTS (John Street, Adelphi, W.C.).—8 p.m.: pr J. Cantlie: The Part played by Vermin in the Spread of

ROYAL SOCIET OF ARIS (SOME SCHEE, Augmin, W.C.).—S. P.M. Dr. J. Cantlie: The Part played by Vermin in the Spread of Disease.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Walcs's General Hospital, Totterham, N.).—Clinics: 2.50 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

#### THURSDAY, JANUARY 28TH.

CRILD STUDY SOCIET LONDON (Parkes Museum, Margaret Street, W.).—8 p.m.: Discussion on the Report of the Royal Commission on the Care and Control of the Feeble-minded (opened by Dr. G. Shuttleworth, Mrs. E. M. Burgwin, and Mrs. Dickenson Berry. M.D.).

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINDDOM (11, Chandos Street, Cavendish Square, W.).—8 p.m.: Card Casea. 8.50 p.m.: Mr. W. B. Harman: (1) Four Generations or Lamellar Cataract; (2) An Unusually Rapid Development of Complete Cataract in a Boy.—Mr. D. J. Wood: A Case of Retinal Exudation with Extreme Distension of Vessels, and perhaps Arteriorenous Anastomosis.—Mr. A. S. Percival: (1) Note on the Colours of Benham's Top; (2) Note on Some Rhythmic Oscillations of the Pupil.

Pupil,
NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's
General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological
Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr.
A. J. Whiting); Surgical (Mr. H. W. Carson); X.Fays. 3 p.m.:
Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Special
Demonstration: Dr. T. R. Whipham: Cases of Children's Direases.

#### FRIDAY, JANUARY 29TH.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.1a.: Medical In-patient (Dr. R. M. Judic).

### Appointments.

DE KOCK, J. G., M.B., Ch.B.Edin., House Surgeon at the Royal Eye Hospital, Southwark, S.E.
GLOVER, B. T. J., M.B., Ch.B.Liverp., School Medical Officer to the Liverpool Education Committee.
GRIPPITH, A. E., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Lydbrook District of the county of Gloucester.
HAWKSLEY, W. L., M.B., Ch.B., D.P.H.Liverp., School Medical Officer to the Liverpool Education Committee.
MAYER, CLIFFORD A. L., M.D., B.S.Lond., M.R.C.S., L.R.C.P. Lond., Senior Resident Medical Officer at the French Hospital, Schere, Gerald Morgan, M.R.C.S., L.R.C.P.Lond., prof. tem., Public Vaccinator for the Kingswear District of the Totnes (Devon) Union.
TROYTER, G. CLARK, M.D.Edin., D.P.H.Aberd., Medical Officer of Health for the Burgh of Paisley.

### Vacancies.

Sussex County Hospital, Brighton.—Stephen Ralli Memorial.—
A Pathologist.—Salary, £350 per annum, and half the fees earned in private practice. Applications to the Secretary of the Hospital.
Bristol General Hospital.—Senior House Surgeon. Salary, £120 per annum, with board, residence, etc. Applications to the Secretary.
Rotherham Hospital and Dispensary.—Senior House Surgeon. Salary, £110 per annum, with rooms, commons, and washing. Applications to the Secretary, H. Kelson, Masonic Buildings, Rotherham.
Northampton General Hospital.—Senior Resident Medical Officer.—Salary, £120 a year, with apartments, board, washing, and attendance. Applications to C. S. Risbee, Secretary-Superintendent.
Durham County Asylum.—Junior Assistant Medical Officer.

Superintendent.

Durham County Asylum.—Junior Assistant Medical Officer.

Salary, £150 per annum, with board, laundry, and attendance. Applications to the Medical Spuerintendent. Durham County Asylum. Winterton, Ferryhill.

Surrey County Lunatic Asylum, Brookwood, near Woking.—

Second Assistant Medical Officer. Salary, £200 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent of the Surrey County Lunatic Asylum, Brookwood, near Woking.

Kensington General Hospital, Earl's Court, S.W.—Assistant Surgeon and Ophthalmic Surgeon to the Hospital. Applications to Louis C. McCausland, Secretary.

Cambridgeshire, etc., Asylum.—Senior Assistant Medical Officer.—

Salary, £150 per annum, with board, lodging, and washing in the Asylum. Applications to T Mugrave Francis. Clerk to the Visitors, 18, Emmanuel Street, Cambridge.

### Marriages.

WILLIAMSON—GRAHAM.—On Jan. 19th, at St. Matthias's, Richmond, John Williamson, M.B., C.M., Rothesay House, Richmond, to Lilian, younger daughter of the late Duncan Graham, of Lydiate, Willaston, near Chester, and of Mrs. Graham, Lansdowne View, Richmond.

### Beaths.

FRANK.—On Jan, 22nd at 3, Elvaston Place. London, the Lady Agnes Frank, wife of Dr. Philip Frank, in her 79th year.

HILL.—On Jan. 22nd. near Andermatt, Switzerland, the result of an accident, Lieut. Herbert E.W. Berkelev Hill, Middlesex Regiment, youngest son of the late Berkeley Hill, M.B., F.R.C.S., and of Mrs. Berkeley Hill, 49, Gloucester Terrace, Hyde Park, aged 21 years. Jones.—On Jan. 23, at 6, Riviern Terrace, Dawlish, Herbert C. W. Jones, M.A., M.B. Cantab., M.R.C.S., L.S.A., late of Acton, eldest son of the late William Jones, formerly H.B.M. Vice-Consul at Havre, and Mrs. Jones, La Quinta, Dawlish. Young.—On Jan. 13th, at Holme Cottage, Paignton. Augustus Warren Young, M.A., T.O.D., youngest son of the late Plowman Young, M.D., of Bury St. Edmunds, in his /2nd. year. R.I.P.

### A few typical letters from Medical Men

about

# ANGIER'S EMULSION

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Dear Sirs,—I have used Angier's Emulsion in a number of chest cases, notably in cough following influenza and in the later stages of bronchitis in children, and have never known it to fail. In one case of advanced phthisis it gave a good deal of relief. After trial in a multitude of chest cases, I consider it far superior to all other emulsions.

(Signed) ———L.R.C.P., L.R.C.S.

### "Derived much benefit after an attack of Pneumonia."

Dear Sirs,—Having during the past two winters derived much benefit from taking Angier's Emulsion after an attack of pneumonia, I am, with excellent results, using it largely both in my private practice and also amongst my hospital patients.

(Signed) -----M.R.C.S.

# "Especially valuable in Chronic Bronchitis."

Dear Sirs,—I find Angier's Emulsion especially valuable in chronic bronchitis, and I have no less than seven patients who are at present using it with very marked benefit. In two cases, accompanied with asthma, the effect is very marked indeed. I have observed recently that the stomach can continue to take Angier's Emulsion almost indefinitely without any bad effects, hence I have had patients who were taking other emulsions abandon them in favour of yours. I know of no other preparation from which such excellent permanent results have been obtained. (Signed) L.F.P.S. Glas. & L.M.

## "Excellent results in the treatment of Mucus-Colitis."

Dear Sirs,—I send you this short note to tell you that I have got excellent results in the treatment of mucus-colitis from the administration of Angier's Emulsion. It is in my experience by far the most useful preparation in such cases. Also in Bronchitis, specially of old people who cannot digest cod-liver oil, I find your Emulsion very valuable. I have not got as good results from any of the imitations, and I invariably prescribe Angier's.

(Signed) ———M.B., etc.

## "I prescribe it to more than half my patients."

Dear Sirs,—In all cases of chronic cough, and in all wasting diseases of adults and children, pulmonary and gastro-intestinal, I find no better tonic than Angier's Emulsion. I prescribe it to more than half my patients. You may make use of this testimonial minus my name.

(Signed) ———L.R.C.P., L.R.C.S., &c.

### "Decided benefit in troublesome Bronchial Catarrh."

Dr. — begs to thank the Angier Chemical Co., Ltd., for their Angier's Emulsion, which he has taken with such decided benefit in troublesome bronchial catarrh that he is pleased to add his testimony as to its great value as a tonic and to endorse every word of their prospectus as to its effects and advantages over other emulsions of fatty medicines, generally so nauseating, but in this case positively pleasant to take.

(Signed) — L.R.C.P., M.R.C.S.

## "It is as well adapted to children as to adults."

Dear Sirs,—I have pleasure in stating that I have used Angier's Emulsion now for a period of over three years in my practice with great success, both in acute and chronic stages of pulmonary diseases, also in gastro-intestinal disorders, especially of a catarrhal, ulcerative, and tubercular nature. It is as well adapted to children as to adults. I use no other emulsion.

(Signed) ----L.R.C.P., L.R.C.S.

# Catarrhal Tracheitis Patient over seventy.

Dear Sirs,—I have tried Angier's Emulsion on my wife, who was suffering from an acute attack of catarrhal tracheitis and was over 70 years of age. I gave it in maximum dose an hour after breakfast time—once a day only. In ten days the awful tickling cough, which no drug or treatment ever restrained, almost entirely left her and within seven days more was gone. I therefore, unsolicited by you, feel I ought to state the case for the good of others.

(Signed) ——M.D. Edin.

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- 4. It contains the maximum proportion of the proximate principles of food.

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY FEBRUARY 3, 1909.

No. 5.

### Notes and Comments.

THE paucity of medical men in the Medical Men House of Commons is a stock subject of lamentation amongst those Parliament. that hope to better the conditions of our profession. Of the few niedical men who write "M.P." after their names, the majority sit in Parliament as political and party Parliament. representatives. Indeed, it is the exception rather than the rule for them to interfere in the discussion of matters of medical interest. One of our best friends in the House of Commons is probably Sir Batty Tuke, who has always stood up manfully in the defence of professional interests. Amongst others, thanks are due to Sir William J. Collins, M.D., who has done good service during the few years he has been in Parliament. One successful effort of the kind is noted at length in the leading columns of our present issue. It relates to the extraordinary lapse from ordinary good taste and patriotism involved in the appointment several years ago by Sir Claude Macdonald of a German medical man to the Embassy at Tokio, the capital of Japan. Sir William Collins brought the matter to the attention of Sir Edward Grey in a series of pointed parliamentary questions. Although the matter was shelved and evaded at the time with the skilful circumlocution apparently inseparable from Foreign Office methods, we are glad to say that the justice of Sir William's contention has been tacitly conceded by the tardy substitution of an Embassy medical officer holding a British qualification.

Why not
More Medical men in Parliament are not
far to seek. The demands upon the
"M.P.'s"?

time of the Members are more and
more exacting, and, at the best, are

well-nigh impossible to anyone conducting a large practice. Some few exceptional men are able to do their duty in the House and not neglect their hospital and private consultant or specialist practice; but these are necessarily few and far between. Then there is the matter of the cost entailed in the membership, both as regards elections, the nursing of constituencies, and the actual expenses incident to residence and other matters pertaining to the parliamentary sessions. It seems likely that these various obstacles are so great as to render anything like adequate representation of medical men in the Commons out of the question, unless and until the matter is treated as a collective duty, and the expenses of a certain number of medical men be paid, as in the case of the Irish and the Labour parties. The medical profession, in the aggregate, can wield an enormous political power, and it is not improbable that, were the initial money difficulty overcome, they would be able to command the polls in a sufficient number of constituencies to satisfy all the needs of the situation. So mote it be!

Army Medical Promotion. THERE are already to be heard grumbles about the system of promotion adopted in the Royal Army Medical Corps some eighteen months ago. Under the reforming hand of

Mr. Haldane-whom we are proud to recognise as a brother-scientist, in spite of his legal attainments -a move was made in the direction of abolishing promotion by seniority in favour of promotion by merit. To this end, a board consisting of six majorgenerals on home stations was appointed to advise on the advancement of officers. The plan was welcomed generally by the corps, both as substituting a logical system for an automatic one, and also as placing members under the control of their own professional superiors. In human affairs, alas! there is always some defect, and such a system always exposes administrators to the charge of favouritism. Indeed, the old method of seniority promotion was really a reaction against the jobbery that previously went on. And so the action of the board in selecting certain officers and passing over others is being criticised, though, from what we gather, there is really no serious charge brought against it. The corps has suffered so much in the past from dissensions inside and outside the ranks, and the way has been so favourably prepared by Lord Middleton and Mr. Haldane for peaceful progress, that we trust satisfaction will reign for many years to come.

Coleridge v. Kidd. THE amicable relations which exist between the various anti-vivisection societies were exhibited again by a summons heard in the Chancery Division last week before Mr. Justice

Joyce. The point at issue was which society, Mr. Coleridge's or Miss Kidd's, was entitled to a legacy of £200 left by a benevolent lady, Miss Caroline Goldsmid, "to the treasurer for the time being of the Anti-Vivisection Society, Bristol Branch, for the purposes of the said Society." The Bristol branches of the two societies each put in a claim for the legacy. As Miss Goldsmid was a life member of the British Union for the Abolition of Vivisection, and had never subscribed to the National Anti-vivisection Society, one would think it plain that the Bristol branch of the former concern was intended. However, an anti-vivisectionist is nothing if not militant, and as the dispute continued, it became necessary to obtain a legal interpretation of the will by means of an originating summons. Mr. Justice Joyce said that there was no doubt that the

British Union was intended, and awarded the legacy to it, or perhaps we should rather say, what was left of the legacy after the legal gentlemen concerned have all had their share. An interesting observation fell from his lordship in the course of the announcement of his decision—that the Bristol branch of the National Anti-vivisection Society "appeared to be only for the purpose of collecting funds and remitting them to the head office in London"!

The Mother State.

The Woman's Labour League, in session at Portsmouth, was occupied with a number of social questions of grave moment, but as the whole tendency of all these debates is to

centre on Socialism, the amount of immediate practical utility would seem to be small. All of those who have thought of the influence which the labour of married women has on the home must have been struck both with its immense social and hygienic importance, and with the difficulty of tackling it. One good lady gaily suggested that all married women should be forbidden by law from working for their living—a proposal which could only come from a person wholly unacquainted with the necessities of the situation. Another lady, Miss MacArthur, declared that what is necessary is, that the State should make provision for mothers four months before child-birth and a year afterwards. That, perhaps, is nearer the mark, but we fail to see how it could be carried into practical effect; the dangers of it, however, are obvious, for the next step is clearly to make the State responsible for the children altogether-an arrangement which would, no doubt, tend to increase the population, but without taking count of the sort of citizen which would result. The difficulty is to preserve the home, protect the mother, and preserve the independence of the individual. A practical solution is still awaited.

A GOOD stand is being made at Brentford by the medical men of the 3½d. a Visit. district, who have combined together and refused to accept less than 65. per head per annum from members of

the friendly societies. In South Manchester and the neighbourhood a similar stand was recently successfully maintained. It is asserted that the present rate of 4s. in Brentford averages out at 3½d. a visit! We only wonder that the profession has taken no concerted action before. The friendly societies must have the interests of their own members very little at heart, or they must be extraordinarily impervious to the facts of life, if they imagine that careful modern medical treatment can be meted out at such rates. The worst form of economy for a working man who depends on his own exertions is economy in medical treatment when he is ill, and the sick funds of the societies are likely to be largely depleted through the prolongation of members' absence from work if they are not adequately and fully treated for their complaints.

### LEADING ARTICLES.

THE FOREIGN OFFICE AND AN OFFICIAL MEDICAL APPOINTMENT.

In the year 1905 the attention of the medical profession of the United Kingdom was drawn to a curious state of affairs affecting their dignity and standing in no less important a country than that of Japan: We are glad to say that the particular rock of offence in question has

been at length removed, thanks mainly to the exertions of Sir William J. Collins, one of the few representatives of the medical profession in the House of Commons. Although the incident is now happily concluded, the matter, nevertheless, has so much inner significance that the story and its moral may with advantage be brought to the recollection of our readers. It appears that there are some seven British embassies and consulates to which medical officers are appointed; the posts are salaried and non-pensionable, but the holders have the right to carry on private practice. One of these posts at Tokio, the capital of Japan, was for a long time held by a German medical man, and when the post became vacant it was conferred by Sir Claude Macdonald, the Ambassador at Tokio, upon another German. The legality of such an appointment is open to serious question, inasmuch as the Embassy, by a legal fiction, stands upon British soil, and is open to foreign medical practitioners only upon clearly defined conditions. As to the moral effect of such a step, there can be no hesitation in describing it as disastrous. The Japanese, a shrewd people, seeing the Embassy going to Germany for its medical advisers, immediately jump to the conclusion that English people have greater faith in German medicine. Whether this motive be responsible or not, it is a fact that of recent years Japanese students have to a great extent deserted our own medical schools for those of Germany. Who can wonder at such a preference when the English Ambassador, who is placed in Japan to foster and protect British interests, sets so poor an example of faith in our medical men? Sir Claude Macdonald, however, may rest assured that in the field of actual practice, as apart from arm-chair pedantry, the British practitioner stands unrivalled as a sound practitioner abreast of the principles of modern scientific methods. When Sir Claude Macdonald's attention was drawn to the undesirability of appointing a foreigner to so important a post, he responded in a way that appears to be derogatory of the traditions of dignity and of patriotism that should distinguish a British Ambassador to a great nation like Japan. The matter was taken up in the medical journals, and a remonstrance addressed to His Excellency by the British Medica! Association. We had always imagined that a British Ambassador was responsible solely to the Foreign Office, but Sir Claude took the extraordinary step of corresponding with the Association in defence of his action. That communication, in our opinion, stands self-condemned, inasmuch as it descends to the extremely undignified level of attempting to belittle a gentleman, Mr. S. G. Kirkby-Gomes, a Fellow of the Royal College of Surgeons of Edinburgh, who was at the time resident in Tokio as professor of surgery at the College of Medicine, and who, in our opinion very properly, had drawn the attention of the Association to the facts of the Embassy appointment. The Ambassador further stated to that body, in so many words, that he had not appointed the German until every means of obtaining an English candidate had been exhausted. To that assertion Mr. Kirkby-Gomes pertinently inquired whether the vacancy had been advertised in one of the home medical journals—a question that we believe still remains unanswered. If Sir Claude

Macdonald's original appointment was bad, his defence appears to be many times worse, inasmuch as it reveals an arrogance and a failure to grasp the essentials of a position that are simply startling to find in connection with a British Ambassador. His attitude throughout the affair has been practically censured by Sir Edward Grey and the Foreign Office by the recent appointment to the Tokio Embassy of a practitioner holding a British qualification. Sir Claude Macdonald, whose services were transferred from China to Tokio after the Boxer rebellion, has neither added to his laurels nor increased the prestige of his office and of British medical science by his handling of the medical officership of the Embassy in Tokio. The Diplomatic Service is, for the most part, a mystery to the man in the street, but if it fail in so elementary and obvious an international duty as the defence of that medical science of which we as a nation are so justly proud, then the sooner the traditions of the Foreign Office are rehabilitated the better for the Empire. Meanwhile, the thanks of the profession are due to Mr. S. G. Kirkby-Gomes and Sir William J. Collins for their spirited and disinterested action in the defence of professional rights.

### RADIUM IN SURGERY.

THE newspaper reading world has been startled lately by the report of a lecture by Sir Frederick Treves on the use of radium in surgery, and still more so by the announcement that Sir Ernest Cassel has allotted a large sum to endow in perpetuity an institute for the scientific study of radium and its application to clinical cases. Since Sir Frederick Treves was "unmuzzled," by reason of the fact that he retired from practice, he has been acting somewhat the part of a medical fat-50y whose delight is to make the flesh creep, and his outspokenness and assurance, which were so well known in professional circles for the last two or three decades, have enjoyed a wider vogue since his successful operation on the King. Now, we have nothing more to say of his lecture on radium than that we hope the outlook of that element in therapeutics is all that is there painted. If radium will heal epitheliomata, rodent ulcers, nævi, and other superficial growths and formations with the case which Sir Frederick describes, no one would be more delighted than ourselves. At the moment we can only say that, our own experience not having been so satisfactory as Sir Frederick's, we are not in a position to say more than we shall be glad to know in what direction we have erred, and trust the mistakes of the past may be rectified in the future. There are three sets of emanations from radium, says Sir Frederick, namely, alpha rays, of low velocity and penetrating power, beta rays, of great velocity and penetrating power, and gamma rays, of enormous velocity and penetrating power, the latter two varieties being inseparable. fault which has prevented other observers from obtaining results as good as those seen by Sir Frederick Treves is, according to that authority, that they have not applied the radium in the correct way, which consists in using a little of the element spread over a large surface. Employed in this

manner, radium acts much more powerfully than when a piece of it is placed in a tube, and is capable of destroying epitheliomata and other lesions which X-rays have failed to effect. Distance and duration are important factors in the treatment, and these can only be learned by time, trouble, and experience, and they vary according to the result the surgeon wishes to secure. But external treatment is by no means the only kind which Sir Frederick Treves conceives to be within the therapeutic purview of radium. He discussed the inhalation of radioactive substances into the lungs, and cited an instance in which an experimenter had injected a radio-active solution into a mouse suffering from artificial cancer. The result of the latter research was the rapid disappearance of the growth. Well, far be it from us either to doubt the facts or to chill the ardour of those working on this wonderful and little-understood substance. We trust such studies may be brought to the happiest fruition in the treatment of disease and the increase of longevity. But we cannot help thinking it a little odd that Sir Frederick Treves, who was during his active career as a practising surgeon such an ardent advocate of operation as opposed to medical measures, should be the mouthpiece of the new treatment. That in itself is no reflection, but only one of the little ironies of life. And, further, we must deprecate, though we feel somewhat churlish in doing so, the flourish of trumpets over the endowment and foundation of the new institute. Perhaps, like the Pharisees of old, we are inclined to take the jaundiced view-can any good thing come out of Nazareth? On the other hand, looking back on an endless vista of alleged therapeutic triumphs, heralded into the world with every circumstance of promise, and seeing at the end nothing but disappointment, we feel we can safely say that the drums, the trumpets, and the laurel-leaves, come better after the race is won. Let us hope that radium may be all that is announced, but let us wait before acclaiming it till we have complete demonstration. And, further, let us hope that there may be none of the tragedies among workers in radium which have so cruelly overtaken the earlier X-ray experimenters.

### CURRENT TOPICS.

The Research Defence Association.

Few societies can boast of the rapid progress shown by the Research Defence Association during the twelve months since its foundation. It is just a year ago that seven men met round Mr. Stephen Paget's dining-table-a table at which many great men have foregathered in times past-and decided to found the Association. To-day more than 2,200 members have been enrolled, and the Dublin meeting last week showed that the movement is still growing rapidly. It was time that the resistance to the anti-vivisectionists should be organised, and brought to bear directly on public opinion. By their noise, rather than by any inherent force in their reasoning, the anti-vivisectionist party has made itself felt, for, whenever anyone shouts loud enough, the English public thinks there must be something worth hearing. In Dublin this winter it is said that the Hospital

Sunday Fund suffered severely by reason of an attack from some untruthful statements made by anti-vivisectionists. It is very gratifying, therefore, to find the hearty response of the best elements of the public to the appeal of Mr. Stephen Paget and those associated with him in the Research Defence Association. Professional men of all kinds, business men, clergy, public men, with large numbers of ladies, were present at the meeting in Dublin. It is needless to say that the Association has the hearty and unanimous support of the medical profession. Sir Henry Swanzy, who must be regarded as directly responsible for the foundation of the Dublin branch, is to be heartily congratulated on the results of his labours.

### Live Burial.

It is curious how, from time to time, the fear of being buried alive crops up in the public mind. A few years ago, on the death of a well-known antivivisectionist lady, it was declared that she had given directions that her heart should be transfixed in order to ensure that death had occurred. Last week, in an advertisement in an Irish paper regarding the estate of a gentleman recently deceased, there was notice of the bequest of two guineas to a Dublin medical man for the performance of a similar test of death. While it would be futile to deny that under certain circumstances, as, for instance, during a cholera epidemic, persons may have been buried alive, it may be stated without hesitation that under ordinary conditions such an event never occurs. Those who dread live burial rely to a great extent on the distorted condition in which bodies buried for some time may be found. But they entirely reject the known fact that putrefaction may produce the most curious distortions, and that violent effects on the coffin, even to the bursting of a sealed leaden casket, may be brought about by the gases produced by putrefaction.

Nursery Schools.

Now that the folly of sending children under five years of age to school is becoming recognised, not only by the Board of Education, but by a good many local authorities as well, the serious question arises as to what is to be done for children who have hitherto attended the infant classes at schools. One of the proposals is that so-called "nursery echools" should be established, and that these should be conducted somewhat on the lines of the crêche, that is, as institutions to which parents may send their children with the frank intention of getting rid of them for the day. There is a good deal to be said for such institutions, but the most important point about them is that they should not be regarded as, or conducted on, the principle of the school. That education, as ordinarily understood in the school curriculum, is not only unnecessary for, but positively harmful to, children under five, is accepted by all who have studied children scientifically, and it is recognised, moreover, that any teaching between the ages of five and seven must be of the simplest description, and conducted on quite different principles to those usually adopted. In our educational system, however, there is no room for any nursery schools without a complete overhauling of all the machinery, and it is doubt-

ful if they can be grafted on anything which at present exists, without there being confusion in people's minds as to their object. Such nursery schools, in fact, should be not schools at all, but playrooms, and it is far from certain that the authorities at Whitehall would give grants to institutions, by whatever name called, which did not even profess to instruct. Whilst unreservedly condemning any attempt to begin a child's education so early, we tear nursery schools would still present another of the great objections to the present infant departments, namely, that they would continue to act as the hotbeds of infection for measles and whooping-cough. The subject seems to us part of a far wider one. The natural and proper place for children of tender years is the home, and their proper guardian and teacher is the mother. No institution and no teacher should be needed to supply the place of either, and we cannot but believe that the whole position is a strong argument against married women during active sexual life going out to work, or being looked upon as wage-earners at all.

The Ethics of Dispensing.

In a recent number of The Pharmaceutical Journal there is the report of an interesting paper on the relations that should exist between prescriber and dispenser in cases where difficulties arise. In some cases—less numerous than the article in question seems to imply-a dispenser is presented with a prescription which, either by reason of incompatibility or of massive dose, seems to him to present elements of danger. What is his duty under such circumstances? The obvious answer is, that he should communicate with the prescriber. It seems, however, that some dispensers are chary of doing this, in view of the possible snub they may receive. Mr. McEwan relates the case of a dispenser to whom was presented a prescription ordering 20-minim doses of dilute hydrocyanic acid. He communicated with the prescriber, who requested him to dispense the prescription as it stood. He did so, but the prescriber wisely called on the patient at once and altered the dose. It seems to be impossible to lay down any absolute rule on the point. Every case must be decided on its merits. With a sincere desire on the part of the pharmacist to protect the public, and at the same time to maintain the confidence of the patient in his physician, few real difficulties will arise. While a dispenser has in most cases done his duty in drawing the attention of the prescriber to any possible danger, yet there is no doubt that, if still unsatisfied, he has the right to refuse to dispense. In his own interests he is not likely to enforce this right at all frequently, but a pharmacist is no more bound to dispense every prescription presented to him than a medical man to advise every patient who demands his services.

"Running Amuck."

The terrible outburst of madness known in the East, especially in the Malay, as running "amok," has been converted into the easier phrase, "running amuck," by British sailors. As we all know, the unhappy victim of the frenzy attempts to kill everyone he meets, and the condition is essentially one

of acute homicidal mania. As a form of insanity, it affects individuals, and, happily, does not permit of the co-operation or concerted organisation of two or more persons. That fact at once upsets the theory that the two desperadoes who were chased for miles the other day in the outlying suburbs of London were victims of this particular form of madness. Had there been only one ruffian firing his revolver indiscriminately at everyone within range during several miles of a wild race on motor, tram and other vehicles, he would probably have been a case of a man gone "amok." But there were two assassins, who had first planned a deliberate robbery, and left their home laden with cartridges for their criminal fight. Theirs was the organisation of intellectual sanity, whatever may be said of the moral failure that could have rendered possible the development of such collective ferocity.

### PERSONAL.

THE KING has appointed Mr. George Anderson Berry, M.B., C.M., F.R.C.S.Ed., to be Honorary Surgeon Oculist to His Majesty in Scotland in the place of the late Dr. Argyll Robertson.

HIS MAJESTY THE KING has graciously granted permission to Dr. George Ogilvie to accept and wear the Insignia of Knight of the Royal Order of Isabel la Católica, conferred on him by the King of Spain.

PRINCESS CHRISTIAN has given her patronage to the matinite which is to take place at the Queen's Theatre, Shaftesbury Avenue, on Thursday, February 18th, in aid of the funds of the Royal Ear Hospital, Dean Street.

PRINCESS CHRISTIAN was present at a meeting of the League of Mercy held at the St. James's Theatre on January 28th. The speakers included Sir W. J. Collins, M.P., M.D., Captain H. M. Jessel, Mr. H. B. Irving, and the Mayor of St. Pancras.

Dr. Albert T. Ozzard, of British Guiana, has been elected to the West India Committee.

Mr. RUSSELL HOWARD, M.S., F.R.C.S., has been appointed surgeon to the Poplar Hospital.

SIR WILLIAM GOWERS, F.R.S., will lecture at University College Hospital this afternoon on "Unilateral Optic Neuritis from Cerebral Tumour."

THE British Association is to meet this year at Winnipeg from August 25th to September 1st. Profesor Sir J. J. Thomson, F.R.S., is the President-Elect.

Dr. RAMBAUT. Superintendent of the County Asylum at Bicton Heath, was last week the recipient of a hand-some present, subscribed for by members of the staff, on the occasion of his marriage.

MR. HERBERT C. MOONEY, M.B.R.U.I., F.R.C.S., Assistant Surgeon to the Royal Victoria Eye and Ear Hospital, has been appointed Assistant Surgeon to the Ophthalmic Department of St. Vincent's Hospital, Dublin.

Dr. Sidney Martin, F.R.S., is giving the Lettsonian Lectures of the Medical Society this month on "Functional Disorders of the Stomach and Intestines, their Diagnosis from Organic Disease and their Treatment."

LIEUT.-COLONEL J. W. T. GILBERT, V.D., Royal Army Medical Corps (Territorial), has received His Majesty's permission to accept the silver medal of the Order of Orange-Nassau, confered upon him by the Queen of the Netherlands.

THE Nottingham Medico-Chirurgical Society have presented Alderman Dr. F. R. Mutch, who recently resigned the Chairmanship of the Health Committee of the Corporation, with an illuminated address in acknowledgment of his services to the city.

By invitation of the Council of the Royal Society of Arts an illustrated lecture was given by Dr. James Cantlie on "The Part Played by Vermin in the Spread of Disease" on Wednesday, January 27th, at the Society's rooms. The chair was taken by Sir Malcolm Morris, K.C.V.O.

SIR JOHN TWEEDY, F.R.C.S., is to preside at a meeting to be held on Tuesday, February 9th, in the library of the Royal College of Physicians, in support of the British Medical Benevolent Fund. The Lord Mayor, the Bishop of Oxford, and Sir Douglas Powell, K.C.V.O., will be amongst the speakers.

A COURSE of eight lectures on National Eugenics, in connection with the Galton Laboratory, will be given at University College, London, on Tuesdays at five o'clock, beginning on February 23rd. The first lecture will be given by Professor Karl Pearson on "The Purport of the Science of Eugenics."

LORD ROBERT CECIL will take the chair at the dinner of the London School of Clinical Medicine, to be held at the Savoy Hotel, on February 19th. The guests will include Sir Thomas Smith, Bart., Sir William Church, Sir William Collins, M.P., Sir Malcolm Morris, K.C.V.O., Sir Thomas Barlow, and Sir R. Douglas Powell, K.C.V.O.

THE annual meeting of the After Care Association for poor persons discharged recovered from asylums for the insane will be held at 26 Devonshire Place, W., this afternoon, when the chair will be taken by Dr. G. H. Savage. A paper will be read by Dr. Robert Jones on "The Urgent Necessity of Helping Mental Convalescents."

THE Third Annual Dinner of past and present students of the Royal London Ophthalmic Hospital will be held at the Trocadero Restaurant on February 10th, under the presidency of Sir Anderson Critchett, Bart., C.V.O. The hon. secretaries are Mr. Arnold Lawson, 12 Harley Street, W., and Mr. J. Herbert Parsons, 27 Wimpole Street, W.

Four lectures will be delivered on Tuesday, February 9th; Wednesday, February 10th; Thursday, February 11th; and Friday, February 12th, 1909, at Gresham College, Basinghall Street, E.C., by F. M. Sandwith, M.D., Gresham Professor of Physic. Lecture I. will deal with "The Results of Recent Research on Certain Diseases"; Lecture II. with "Diphtheria"; and Lectures III. and IV. with "The Life-work of Pasteur."

The annual general meeting of supporters of the Queen Alexandra Sanatorium, Davos, was held at the Grand Hotel and Belvedere, Davos-Platz, on January 20th. Dr. W. R. Huggard, Chairman of the Board of Management, who presided, announced that Lord Balfour of Burleigh, President of the Institution, had recently received from Lord Strathcona a donation of £2,000. Dr. Huggard said that the King had given special permission for the Royal Arms to be placed on the building in stone.

### A CLINICAL LECTURE

### SIMULTANEOUS EXISTENCE OF CONGENITAL AND ACQUIRED DISEASE OF THE HEART.

By PROF. A. DIETRICH. M.D.

Prosector at the Krankenhaus, Westend-Charlottenburg, Berlin,

[SPECIALLY REPORTED FOR THIS JOURNAL.]

I wish to describe to you in few words a heart that is not specially remarkable itself, except that it contains in a remarkable manner a combination of unimportant congenital peculiarities and acquired changes that, together, make up an exceedingly grave condition. For this reason the case is of interest to the practitioner regarding the clinical features and a comparison of them with the anatomical condition.

The heart is from a man, æt. 42, who, on account of a "weak chest," was not taken for a solider, but who was ignorant of any heart mischief. As a child he had measles and scarlatina, and twenty years ago he had a long attack of sciatica. He married and had children, but ten years ago he had both syphilis and gonorrhea. In the beginning of 1907, some nerve trouble led him to a nerve specialist, who diagnosed disease of the heart, of which the patient knew nothing. Since May of the present year he has had a cough, palpitation, and sleeplessness. These troubles increased to such a degree that he could scarcely get about, and led him to seek admission into hospital.

On examination of the patient, an elastic fulness of the superficial veins, especially those of the thorax and of the eyelids, was a striking feature, but there was no œdema. The dulness over the heart reached upwards to the fourth rib on the right to the middle of the sternum, and on the left to the mammillary line. Breathing systolic and diastolic murmurs were heard over all the cardiac orifices, the impulse at the apex was heaving, pulsation was visible in the epigastrium, and a capillary pulse was distinctly to be felt. The pulse at the wrist was quick and high, regular, and 92. Nothing special was noticeable in the other organs, there were a few bronchitic rales in the lungs, a trace of albumin in the urine, numerous leucocytes, a few red blood corpuscles, hyaline and granular cylinders.

The condition of the patient got worse, at first a pronounced systolic venous pulse was visible in the neck, the radial pulse was irregular, the condition of the heart was otherwise the same. Cheyne-Stokes respiration was present for a time, dulness in the dependent parts of the chest of the right side, weakened respiration, and ædema of

the legs.

The patient then, against the doctors' advice, left the hospital, but returned in eighteen days with still further advanced mischief. Cutaneous swelling over the abdominal walls and hands was, added to the œdema, and the breathing was very bad. The margin of the heart could now be percussed over the right edge of the sternum, and to the left two finger-breadths outside the nipple line. The murmurs showed no change, the pulse was regular, quick, and high. Blood pressure, 175 mm. Ascites was now present, no sediment or albumin in the urine. The odema receded under treatment, but in a few days the temperature, that had hitherto almost always been normal, rose to 39.3°C., at the same time a rasping sound was added to the systolic and diastolic murmurs that gave rise to a suspicion of pericarditis. The cardiac dulness showed no change, dulness was present in the lower parts of both lungs.

After rapid subsidence of the fever, the objective condition remained the same, but it is specially to be noticed that the venous pulsation before mentioned was persistently present. The ædema slowly increased, and also the dulness over the lungs. The symptoms became threatening a week before the fatal termination, in the form of attacks of angina pectoris, which came on with increasing frequency till death took place on March 17th, 1908.

The diagnosis, based on the clinical history thus shortly related, was one of insufficiency and stenosis of the aortic valves, further insufficiency of the tricuspid valves, changes in the cardiac musculature (myocarditis), and, with some probability, pericarditis. The cause of the disease of the heart, however, was not clear, as there had been no acute symptoms previously, and the course was so extremely rapid from the onset of the first symptoms. From all this the physicians in the case expected to see some serious changes in the heart.

The post-mortem examination showed the whole of the thoracic aperture to be taken up with the pericardium, which was filled with a large quantity of clear fluid, but the serous coating was smooth and shining. The heart was twice as large as the fist of the dead man, distended distinctly more in breadth than in height, the breadth at the base was 16 cm., the length in front 12 cm. Both halves of the heart were filled copiously with fluid blood, and but little clot. On pouring in water the aortic valves were seen

not to effect a proper closure.

Inspection of the valves did not reveal any change in the pulmonary or mitral valves; they were well formed, thin, and their edges were smooth; of the aortic valves, however, only the posterior one was delicate and translucent, free and readily movable, the two anterior ones were adherent, and from this spot to a third of the margin of a whitish colour, of an irregular hard character, shortened longitudinally, thickened at the edge, but without any deposit or nodules. The septum formed by the adherent parts was still more contracted than the free margin, so that the two valve sinuses were only separated by a low bar. These changes in the aortic valves, perhaps more marked in the description than as they appeared in reality to the eye, passed over in the bottom of the sinuses into a flat nodular, whitish, callus-like thickening of the inner wall of the aorta, which extended from the valves about 2 cm. up the aorta, bounded laterally by the

two coronary arteries, but so that the right remained quite free and as a round opening, whilst the left was surrounded by the nodular surface and contracted to a narrow lumen. change of the wall of the aorta, to finish with it was to the eye principally a thickening of the irtima without regressive metamorphoses, in the upper part of the ascending aorta a small flattish prominence was still to be seen, also just above the posterior valve, but the wall of all the other large vessels was quite smooth.

The slight changes of the aorta which microscopically showed the appearances of an ordinary arterio-sclerosis, without signs of any syphilitic causation, first allowed their importance to be estimated by carefully following the coronary arteries of the heart. The usual course of these is that the left coronary artery divides into an anterior vertical branch along the anterior longitudinal fissure, and a horizontal one, which reaches the back of the left ventricle and spreads there into branches, principally in the left lateral angle; the right coronary artery with its main stem runs in the horizontal furrow to the right of the right ventricle, gives off a branch along the right angle of the heart, and runs into the posterior vertical furrow, thus on the borders between the right and left ventricle towards the apex of the heart, but still supplies part of the posterior wall of the left ventricle.

In the case under discussion, the development of the right coronary was but imperfect, from its commencement it was much finer, and did not run over the posterior wall of the ventricle, and the vessel running over the right edge of the heart was the last great offshoot, which could not be followed in the non-injected preparation. On the other hand, the region supplied by the left coronaria was extended. It supplied not only the anterior wall of the left ventricle, and the left angle of the heart, but ran under the large coronary vein, as a large vessel, to the posterior vertical furrow, and in this to the apex. It has, therefore, taken on the duty of the smaller right artery, and with it the whole supply of the cardiac septum on the anterior and posterior sides. The wall of the whole of this vessel is delicate and smooth, but its opening from the aorta is narrowed as we see. With the ill-developed right, this would have been without any consequences as the larger artery by anastomoses of its finer branches, without the specially large left coronary artery on which three-fourths of the heart is dependent, the blood supply of the muscles of the heart must be seriously interfered with.

At the same time, the slight change in the muscles is striking. No necroses are to be seen, no callus from chronic coronary sclerosis, no microscopic degenerative changes whatever are to be seen. The muscles are everywhere red and of firm consistence; the walls of both ventricles are hypertrophied.

But before going further with our consideration of this condition, we must cast a glance on the tricuspid valves. In doing so, the unusual size of the pars membranacea of the septum of the ventricle at once strikes us. Usually scarcely recognisable viewed from the right, covered by the apex of the middle tricuspid, partly situate on it, it forms here a membranous surface 1.5 to 2 cm. in diameter. Above all, the apex of the tricuspid usually inserted into the septum is missing; the strands of tendon springing from

the septum deviate from each other to the posterior valve and to the median valve, present only as regards its posterior half. Between them is a space of nearly a finger-breadth, circular in shape, when the apices of the tricuspid which are firmly attached to the margin are put on the stretch. Here also there are no signs of any old endocarditis; it appears certain that a faulty development was associated with the unusually large membranous septum.

We now have all the peculiarities of the condition, and it is an easy matter to build up the whole of the features of the illness. All the remaining organs showed only the consequences of grave cardiac insufficiency, which I shall not enumerate in detail. The death is due simply to the changes, and to the cardiac paralysis resulting from them. We have two congenital anomalies of the heart, the deficiency in the tricuspid, and the unusual distribution of the coronary arteries. I shall not inquire how far these two are associated from the point of view of development; we shall only consider the importance of the condition. The vascular anomaly has certainly not been a matter of indifference in itself, although the distribution of the coronary arteries varies considerably; at any rate, I have never seen such a wide-reaching diminution of the region of the right coronary artery. Merkel and Jamin, in their atlas of the coronary vessels, have neither figured nor mentioned a corresponding case. The defect in the tricuspid has apparently caused just as little functional disturbance, for this would not have remained unnoticed, and without injurious consequences as regards the rest of the body. patient had his first knowledge of anything being wrong with his heart only a year before his death, no subjective symptoms at the commencement, but from that the illness developed rapidly, insufficiency of the aortic valves at first being in the foreground, so adding to itself the signs of tricuspid insufficiency, and at last angina pectoris, indicating disease of the coronary vessels.

The heart troubles first began with the disease of the aortic valves after inconsiderable arteriosclerosis of the aorta. Whether it was of syphilitic origin, could not be decided anatomically; that simple arterio-sclerosis may occur under the influence of syphilis, is possible, but there is no necessary genetic connection between them. We shall not discuss this point; what interests us is that the sclerotic process covering only a small space, should attack the aortic valves to an equally small extent, and cause insufficiency. This disturbance set up hypertrophy and dilatation of the left heart, and also affected the right heart, now, the tricuspid, hitherto acting satisfactorily, must have failed much earlier than incompensated failure of the left heart usually causes such trouble. Thus, in the early stage of the disease, the congenital defect of the tricuspid added itself to the not severe disease of the aortic valves, in a fateful manner. For compensation in aortic insufficiency is much more difficult to bring about than in mitral insufficiency, and thus the prognosis becomes very unfavourable when organic tricuspid insufficiency becomes associated with it, which by itself alone does not seriously burden the circulation.

We saw the expression of this in the course of the disease, in the onset with vague "nervous" troubles of a quick development, of a difficult compensation, and the complete absence of any temporary improvement worth speaking of. Finally, independent of the transient symptoms of pericarditis, of which no traces could be found at the autopsy, as the last destructive factor, appeared the anomaly of the coronary arteries, at the moment when the sclerotic process reached the point of origin of theleft coronary artery, the importance of which we entered into; at the same time the blood supply to the muscles of the heart, and above all, that of the septum was jeopardised by the defective development of the right coronary artery. As the clinical reaction of this we saw the angina pectoris, the characteristic symptom of contraction of the coronary arteries, which culminated in attacks rapidly following one another, and paralysing the cardiac muscles before the anatomical consequences of the ischæmia had time to develop.

In how far the assemblage of symptoms in the case described, or its individual features, find analogues in individual experiences or in literature will be little discussed as further exposition will be added, or general conclusions sought for, my demonstration has only the practical aim of a critical consideration of the clinical and anatomical pathological features of a case of complicated disease of the heart, and indeed a school case that teaches us the mutual action of a disposition from internal causes, and an external exciting cause, in which a rapidly destroy ng illness grew upon a soil prepared by congenital foundation out of slight acquired changes, in the germ of which the proteus form of syphilis possibly lies hidden.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Denis Kennedy, F.R.C.S.I., Surgeon to Jervis Street Hospital and to the Children's Hospital, Dublin. Subject: "Intussusception."

### ORIGINAL PAPERS.

RADIUM IN SURGERY. (a)
BY SIR FREDERICK TREVES, BART., G.C.V.O.,
F.R.C.S.ENG.,

Consulting Surgeon to the London Hospital, etc.

At the outset of his lecture, Sir Frederick Treves uttered a word of warning to those who might take a too sanguine view as to the powers of radium. It has appeared to me, he said, as it has appeared to many others, that there is possibly a great future for radium in the domain of surgical therapeutics. I say possibly, because one must exercise the very greatest caution when speaking of the potentialities of new remedies. One is tempted to look too favourably upon them. They are things of great expectations, and sooner or later must be associated with disappointment. I need not remind you of all that was looked for from the X-rays, which were to revolutionise surgery. Well, they have not done so, but they have done marvellous work, very marvellous work, but it is not too much to say we are in sight of the point when the limita-tion of their treatment will be found. The same thing applies to the high frequency current, which was to cure every ill—except poverty. There, again, expectations have not been realised. The same also is true, to a certain extent, of the Finsen light. In

the history of hospital administration I believe there never was a more daring enterprise than the introduction of the Finsen light into this institution. It is quite impossible to express in ordinary language the good it has done. I will not preach any new doctrine; I merely wish to speak about the present position, and to invite you to ask yourselves whether you think we are justified in supposing that the utility of radium is likely to be very great. I do not propose to speak of public cases, but only of patients whom I have actually seen and examined.

It may be said that radium can cure every form of nævus. It can cure the port-wine stain, and I should like to ask any surgeon present whether he has any other remedies that will do as much. can rid the patient of the pigmented mole and the hairy mole. Let me take the case of an infant with a nævus the size of a gooseberry on the top of his head. This was cured by a comparatively short application of radium. In another case a girl was suffering from an angioma on her eyelid in size equal to a plum. It has been subjected to four operations, which proved of little use. By radium it was removed. Perhaps the most theatrical case was that of a young woman who had an angioma which covered practically the whole of one side of her face. She had been subjected to innumerable operations, without any success; under radium treatment she was cured. You may say, but these are all affections of the skin. That is so. I will now tell you of a fibrous angioma, which grew to the size of a hen's egg, in a boy's arm. In this case the skin was perfectly sound. After treatment with radium for four weeks it was dispersed. That a solid mass of that magnitude should have entirely vanished in four weeks is marvellous.

Turning to another part of his subject, Sir Frederick continued: It is safe to say that there is a relation between the amount of radium used and the amount of good done. At the present moment we have only small quantities, but we are dealing with a substance that may be regarded as almost limitless in power. This cannot be said of the X-rays or Finsen light. From the fact that this relation exists, we may draw the conclusion that, so far as growths of a certain type are concerned, if only you have sufficient radium you can carry out whatever may be the wishes of the surgeon.

The effect of radium on chronic eczema is well known. Nothing is more curious in the use of radium than the manner in which it cures, and apparently permanently cures, itching. How it does so is a matter which is under consideration. I will say nothing of vanishing glands. In cases where radium has been used on the face, glands in the neck have disappeared. It would, however, be unsafe to draw any conclusion. As regards rodent ulcers, we may say that those of a certain type may be cured by radium. One case in which the ulcer was of many years duration, and in which the tissue had adhered to the bone, was unsuccessfully treated by the X-rays and the Finsen light. A cure was, nevertheless, effected in two sittings with radium, each sitting lasting an hour. I lay stress on this case because it is said that radium only acts by means of its X-rays, but here is an instance of a cure of a complaint which refused to yield to X-rays.

We may ask ourselves—are these results permanent? They apparently are, but, of course, no very great time has elapsed. I think there is enough on which to base our belief in the utility of radium.

Sir Frederick showed a tube of radium of the value of £800. If radium, he added, ever sank to such a degree of cheapness that it were worth

<sup>(</sup>a) Emeritus Lecture delivered at the London Hospital, January 26th, 1909.

its weight in gold, it would, indeed, be exceedingly

Explaining briefly the nature of radium, Sir Frederick said that it possessed rays of three dispinct kinds, and they were known as the alpha, beta, and gamma rays. The alpha rays contained ions which carried a charge of positive electricity, and were deflected only by an intense magnetic field. They had very little penetrating power, and had relatively slow velocity. The beta rays had ions carrying a negative charge of electricity, and were easily deflected by a magnetic field. Their penetrating power was great, and they moved at a very high velocity. The gamma rays differed very much from the other two classes. They contained no ions, carried no electric charge, were not deflected by a magnetic field, and they possessed enormous penetrating power. Their velocity was equal to that of light. In surgery some of these rays were very harmful, while others were highly useful; it was, therefore, necessary to be well acquainted with them. The alpha and the beta rays were separable, but it was impossible to get beta rays without gamma rays. It was interesting to note the relative penetrating power of the three rays. The alpha series, which would barely penetrate a thick sheet of notepaper, might be taken as 1. The beta rays would then be 100. They would just penetrate a centimetre of lead. The gamma rays would be 10,000. They could easily pass rays would be 10,000. through an inch of steel.

The next business, continued Sir Frederick, was the application of the radium. It was absolutely necessary that it should be applied from a flat surface. To attempt to do so from a tube was ridiculous, because the operator, not knowing the proportion of the alpha, beta, and gamma rays, had not the faintest idea of what he was doing. The radium was upon a flat surface, fixed to the end of a short handle. Of one the surface was a little bigger than a postage stamp in size, and contained 90 milligrammes (1.35 grains) of radium. The cost of it was £360. Of another the surface was circular in shape and about one-third of an inch across. The value was £160. Instruments of other shapes are used for applying radium in-

Continuing, the lecturer said that the patient who underwent the treatment did not merely sit in an armchair while someone held some radium near him. It was necessary, first of all, to have a prescription setting forth the proportions of the various rays. The utmost care had to be taken in determining how far from the affected part the radium should be held, and for how long the treatment should be continued. It is a strange treatment, he said. You may apply it on Monday, and it may appear to have no effect, and on Tuesday with the same result, on Wednesday, and on Thursday. On Frida perhaps for the first time, it will begin to react. On Friday,

Other matters in connection with radium and the treatment of disease were also occupying attention. There was the question as to whether tuberculous disease of the lungs could be cured by inhaling the emanations from radium. Another point was whether the injection of a radio-active colution by means of a hypodermic syringe would be beneficial in certain cases. He had been dealing solely with cases in his own experience, but with this reservation he gave the experiment of a brother scientist of high reputation. A cancer had been set up in a mouse, and a solution of radium was injected, with the result that the growth disappeared. In conclusion, Sir Frederick once more begged his medical friends to be cautious as to the way they spoke of permanent cures,

### INFANTILE MORTALITY AS SEEN IN A CHILDREN'S HOSPITAL. (a)

By DAVID FORSYTH, D.Sc., M.D. Lond., Assistant Physician to Charing Cross Hospital : Senior Physician for Out-Patients, Evelina Hospital for Sick Children.

An exact pathological knowledge of the causes of infant deaths is of the greatest practical importance from the point of view of prevention. Hitherto our principal guide in this matter has been the official returns of the Registrar-General, which show the relative importance of various diseases in this connection. These returns, however, are in some cases difficult to harmonise with the experience in the wards and post-mortem room of a children's hospital. Conditions which are known to be frequent causes of death in hospital practice occupy only a relatively insignificant place in the official returns, whilst others which are officially important are, in practice, unimportant. With the object of obtaining statistics based on accurate death-certification, Dr. Forsyth examined the death records of the Evelina Hospital for Sick Children, from January 1st, 1885 to December 31st, 1906, and analysed the causes of 1,202 consecutive infant deaths under one year. The numbers in this series were as follows:

c as lullows				
Acute lung disea	ses		 	254
Diarrhœa			 	188
Whooping-cough			 	135
Tubercle			 	128
Marasmus			 	78
Congenital defec	ts		 	75
Syphilis			 	55
Septic conditions	s		 	44
Intussusception			 	34
Mastoid disease			 	32
Meningitis (non-	tubei	culous)	 	26
Rickets		••	 	13
Convulsions			 	13
All other disease	s		 	127
			1	,202

The method adopted in tabulating these cases was explained, and reasons were given to show that a comparison with the returns for England and Wales was permissible. For reasons specified, the three items, prematurity, measles and whoopingcough were excluded from the comparison. Under the remaining headings, the mortality in the official and in the Evelina Hospital returns strod thus in percentages :-

I			Evelina Hospital.	England and Wales.
Acute lung disease	es		 23.8	21.4
Diarrhœa			 17.6	23.2
Tubercle			 12.0	5.1
Marasmus			 7.3	16.3
Congenital defect	s		 7.0	6.3
Syphilis			 5.2	1.3
Septic conditions			 4.1	
Intussusception			 3.2	
Mastoid disease			 3.0	_
Meningitis (non-to	abero	ulous)	 2.4	2.0
Rickets		••	 1.2	0.58
Convulsions			 1.2	12.2
Injury at birth			 	0.76
Starvation			 	0.7
Other causes			 12.0	10.16
			100.0	TOO 0

Whilst a fairly close correspondence exists between the two series many striking differences must be noticed. Acute lung trouble and congenital defects

<sup>(</sup>s) Abstract of Paper read before the Royal Society of Medicine' an, 22nd, 1909. For discussion se page 000.

show no great divergences. With diarrhoea the somewhat smaller figure that represents the Evelina Hospital mortality is accounted for by two facts: In the summer, when diarrhoea is rampant, the accommodation in children's hospitals is overtaxed, and even moribund cases may be sent away; secondly, it is probable that some of the deaths in the official returns which have been ascribed to diarrhœa would have been registered under other headings if facilities for post-mortem examinations were as great in general practice as in hospitals. With regard to marasmus, a difference of more than 100 per cent. exists between the two series of figures. Since the official return represents over 15,000 dead infants, its interpretation possesses wide practical importance. Marasmus is a term of vague significance and is often employed in connection with conditions of which it is merely a symptom, especially with syphilis, improper feeding and tubercle. It cannot be doubted that deaths from these causes are sometimes registered as due to marasmus, and that a proportion of them should be distributed under other headings. These criticisms apply even more forcibly to deaths from "convulsions," the official returns for which are no less than 1,000 per cent. of the Evelina figures, and represent 11,000 deaths. The term convulsions under no circumstances represents more than a symptom, and when employed as a cause of death merely hides under a meaningless designation important fatal conditions, the returns for which are unduly minimised.

With regard to syphilis, this disease was held responsible in 1905 for only 1,200 infant deaths in the whole of England and Wales—little more than three a day. In the same year, however, 19,000 infants under two months are stated to have died from prematurity. Probably this large figure included the deaths of numbers of syphilitic infants. As a matter of fact, the deaths in 1905 from syphilis of infants under two months amounted only to 300 according to the official returns. Other deaths from this cause must be looked for under the heading "marasmus." With regard to rickets, the hospital figures are twice those for England and Wales. Here we must remember that cases of rickets are often fatal from broncho-pneumonia or diarrhœa, and the primary condition is likely to

be overlooked.

After referring to acute mastoid disease as a cause of infant mortality, Dr. Forsyth passed to the question of tubercle. The Evelina Hospital figures included only those cases in which tubercle was the actual cause of death, and excluded all in which, though a tuberculous lesion was found post-mortem, death resulted from some other cause. The dif-ference in the two series was probably to be explained by the tendency of tuberculous disease in infants to simulate other non-tuberculous affections. Probably the hospital figure, 12 per cent., more nearly represents the real mortality than the official figure, 5 per cent. The frequency, however, with which life is destroyed by tuberculous infections incurred during infancy is under-estimated even by this larger number, because many such cases do not die until their second year, and their deaths do not come into the infant mortality returns. The full importance of tubercle as a factor in infant life would be better revealed by statistics dealing with deaths between one year and fifteen or even eighteen months. At the Evelina Hospital fifty children died of tubercle between these ages. Many, if not most of them, must have been infected during their first

In conclusion, Dr. Forsyth expressed the hope that these Evelina Hospital statistics would lead

to the preparation of corresponding figures from the records of other children's hospitals. An accurate knowledge of the causes of infant mortality can be best obtained from those institutions in which special opportunities exist for ascertaining the exact causes of infant deaths. If, further, the absolute numbers in each series are published, we shall be in a position to draw valuable conclusions based on many thousands of cases. At present 20 per cent. of the mortality, representing 25,000 deaths, is attributed to vague symptoms. When the community has set a proper value on infant life, such terms as "convulsions" and "wasting" will no longer be accepted for death-registration. If no more satisfactory explanation of the cause of death is forthcoming, further steps will be insisted on, as is done to-day with adult deaths. By this means a far-reaching and practical measure will be taken to diminish the present excessive waste of infant

### REMARKS UPON

### SOME GONORRHŒAL DISEASES OF THE EYE. (a)

By SYDNEY STEPHENSON, M.B., C.M., F.R.C.S.E.,

Ophthalmic Surgeon to the Evelina Hospital, the Queen's Hospital for Children, and Queen Charlotte's Hospital.

(Concluded from page 86.)

3.—OPHTHALMIA NEONATORUM.

Or the gonorrhœal affections of the eye, ophthalmia neonatorum is incomparably the most important both from a sociological and a medical point of view; first, because it is relatively often met with, and, secondly, because it is by far the most frequent cause of preventable blindness. At the same time, the best recent statistics appear to show that ophthalmia neonatorum is becoming less frequent. That is cerneonatorum is becoming less frequent. That is car-tainly the experience of most ophthalmic surgeons. Still, that the disease should prevail at all nowadays, when its prevention is so well understood, is little less than a scandal and a reproach to all concerned. fact can scarcely be too strongly insisted upon that a case of ophthalmia neonatorum implies that somebody is to blame. The time has come for plain speaking. I believe that no great progress will now be made in preventing ophthalmia until we are prepared to saddle somebody—be it midwife or medical practitioner—with the responsibility for practically every case of the disease. Let us press this question of personal responsibility home, and we shall assuredly hear less of ophthalmia neonatorum in the future than we have in the past.

Every case of ophthalmia neonatorum is due to the transference (direct or indirect) of infective secretions from the genitalia of the mother to the eyes of the child. This process sometimes comes about at the moment when the infant's head is passing through the introitus, and, as insisted by Mules many years ago, the stretched perinæum plays no inconsiderable ago, the stretched perinaum plays no inconsiderable part in the transference of infection. Another commoner way of infection takes place after the birth of the child, when infective secretion clinging about the lids and lashes is carried into the conjunctival sac by the fingers or blinking of the baby, or by the water, towels, sponges, or other articles used in the first bath.

It cannot be questioned that the eyes may also be infected with the germs of disease while the child is as yet in utero. Many such cases have now been recorded. Thus, in my recent monograph (6) I collected 105 cases—namely, ro of my own and 86 reported by other observers. The current explanation of these cases of so-called "congenital ophthalmia," which we owe to Haussmann (7), is that the membranes have ruptured many hours before the birth of the baby, with the consequence that the gonococci or other causative micro-organisms were enabled to gain entry to the conjunctival sac of the baby, where pos-

(a) Based upon a Clinical Demonstration given at the Polyclinic, ondon, on May 8th, 1908.

sibly the special circumstances hastened and fostered the appearance of the symptoms of ophthalmia. Powerful adjuvant factors were to be found in digital examinations, the application of instruments, or the administration of douches. Haussmann's view has been adopted very generally. But, as I have pointed out elsewhere (loco citato), a careful analysis of the published cases shows that is by no means generally applicable. Premature rupture of the membranes applicable. Fremature rupture of the membranes of ante-partum ophthalmia. The time of rupture of the membranes is mentioned in 71 of the 86 cases spoken of above. The rupture was premature spoken of above. The rupture was premature in 26 of these cases. But in 45 (63.38 per cent.), less than the minimum incubation period of the gonococcus, which I have set down as 24 hours, elapsed between the rupture of the membranes, on the one hand, and the discovery of the ophthalmia, on the other. It is therefore certain that the Haussmann theory, while accounting for some cases, does not account for anything like all the reported instances of ante-partum ophthalmia. The evidence points in the ante-partum ophthalmia. The evidence points in the direction of micrococci being able, under circumstances with which our acquaintance is still imperfect, to penetrate the intact membranes.

Infection of the eyes during passage through the vagina seems improbable under ordinary circumstances, since the junction between the lids, besides being sealed with vernix caseosa, is practically watertight. Nevertheless, it could occur during digital examination, the application of forceps, or, indeed,

anything that caused displacement of the eyelids.

The term "secondary infection" is applied to cases of ophthalmia due to contamination of the eyes some time after birth, such as may take place by the fingers of an uncleanly mother or careless nurse. My personal experience teaches me that a bacteriological examination of the mother's secretions, particularly those from the urethra or the cervical canal, will generally bring to light in these cases of secondary infection the cause in the shape of genococci. Other instances of secondary infection are to be found in one baby inoculated from a second suffering from ophthalmia, or from a nurse or attendant herself affected with gonorrhea. Sonden observed an epidemic of ophthalmia neonatorum, in which gonococci were found in two of the mothers only, and Max Knies, (8) in quoting this case, mentions an epidemic which occurred in the practice of one midwife, who was presumably herself the source of infection. Charbonnier and le Roux (9) saw a gonococcal ophthalmia in a baby of 13 days, and they incriminated the water used in the baptism of the infant as the means whereby infection had been conveyed. A. Pinard's experiences (10) of secondary infections have been of an interesting nature. He had found at his clinique that certain nature. He had found at his cinique that certain foster-mothers, whose own babies were healthy, when allowed to tend other babies, managed somehow or other to pass infection, and thus to start small epidemics of ophthalmia. The little outbreaks were at once suppressed when those women were replaced by others of a more intelligent and careful character.

It has been assumed, in my opinion upon insufficient evidence, that late cases of ophthalmia are mild cases of ophthalmia. Taken collectively, primary are doubtless more to be dreaded than secondary infections, but that is a different matter from claiming, as some have done, that secondary infections in detail are of a mild character. Crede recognised the existence of isolated dangerous cases of secondary ophthalmia (11). As pointed out by Bumm, Krönig, and Steinbuchel, the lochial discharges furnish a favourable medium for the development of the gonococcus. It has been stated by Fruhinsholz (12) that gonococci may often be found for the first time after delivery, having been overlooked even during the later stages of pregnancy. "All investigators," wrote Prince A. Morrow (13), "who have had occasion to examine the lochial fluids, agree in attesting that there is an extraordinary multiplication of the gonococci even as early as the second day." These observations go some way towards explaining why a woman with latent gonorrhoea may not infect her baby's eyes during parturition, and yet may do so during the puerperium by means of the lochia. It appears, indeed, that the maternal infectivity increases during the puerperium owing to multiplication of gonococci in the lochial

fluid during the first few days after labour.

The matter may be summed up by saying that the powers of infection stand in direct ratio to the amount of secretion and to the number of the gonococci, and in inverse ratio to the care exercised by the mother, nurse, and medical attendant.

So much for the actual mechanism of infection. Now, as to the causative agents of infantile ophthalmia, two propositions stand out clearly: first, that the agents in question are identical with the micro-organisms found in the unhealthy maternal passages; and, secondly, that most of them have on occasion been found in the male urethra.

It is important to bear in mind that although nearly all destructive cases of ophthalmia neonatorum are due to and caused by the gonococcus, yet, even in hospital practice, that organism can be found in about two-thirds of the cases only. It is also a noteworthy point that no micro-organisms whatever can be discovered in about 15 per cent. of all cases. Cramer (14) has suggested that such amicrobic forms may be due to injuries sustained by the conjunctiva while the baby is still in utero. Many of them, in my experience, are merely premonitory or concomitant signs of con-genital syphilis. Wertheim (15) has pointed to the existence of degenerated forms of gonococci, which retain their pathogenicity despite the fact that they no longer stain properly. Wertheim's observations are obviously of importance from the present standpoint.

It may be stated in round numbers that of every 100 cases of ophthalmia neonatorum, 65 per cent. will be associated with gonococci, 10 per cent. with pneumococci, 5 per cent. with bacillus coli, 5 per cent. with other pathogenic micro-organisms, and, finally, that in 15 per cent. the bacteriological findings will be negative.

Another point of practical importance is that most cases of ophthalmia in the baby originate from a latent gonorrhea in the mother. It is probable, according to Neisser, that most cases of ordinary acute gonorrhea are contracted from chronic cases (C. F. Marshall) (16). As regards ophthalmia, of 20 women with ophthalmic babies, Groenouw (17) observed pain during micturition in 15 per cent. only of the cases, despite the fact that all the women suffered from vaginal discharges which contained gonococci. Of my own cases, a history of profuse genital discharge and scalding during micturition and local discomfort was obtained in 17 per cent. only. In another 50 per cent. the history was merely of a slight fluor albus. In many of the latter and in some of the remaining cases, which formed 33 per cent. of the total number, the underlying condition was probably a specific endometritis or endocervicitis, the organisms producing which had remained latent until roused into activity, as we now know they may be, by the complex nutritional processes involved in child-birth.

The facts detailed above seriously weaken the position of those who recommend, as Dr. Peter Horrocks (18) has recently done, that in the absence of obvious signs of acute gonorrhea in the mother, the baby's eyes should be left alone. If the symptoms of latent gonorrhea cannot be detected even by a or latent gonormoze cannot be decreted even by a skilled gynæcologist, it is too much to expect that a midwife could do so. Personally, I am convinced that we shall not do our duty as medical practitioners unless we adopt some preventive measure in every case of labour, no matter what social position the mother may happen to occupy. It is no part of my present intention to enter deeply into the question, although obviously such measures will naturally fall into one of two groups, namely, phophylaxis as it affects— (1) the mother, and (2) the child.

(1) Prophylaxis in the mother.—It would seem

reasonable to douche the vagina with some weak antiseptic lotion, as lysol, from time to time during the progress of the labour; but this practice, I understand, has not the approval of most accoucheurs. The objection to the employment of the douche under apparently normal circumstances is obvious even to one who, like myself, possesses no expert knowledge of the subject. But such objections could scarcely apply to a woman who was affected with a profuse coloured

discharge, which all experience pointed out as being of a gonorrhoeal nature. Still, even then, the douche could not be expected to remove all sources of infection, as, for example, from gonococci embedded in the cervical glands. It could, at best, merely reduce the chances of infection, without affording any real security that the baby's eyes would remain free from

The fallacies of the vaginal douche as a means of preventing ophthalmia are shown by the figures given by Credé and Bayer respectively. The former observer by Credé and Bayer respectively. The former observer used the douche in 60 women believed to suffer from genorrheea, but the babies of 14 of these women nevertheless developed ophthalmia. In spite of antiseptic douchings, Bayer (19) still had from 12.9 per cent. to 14.3 per cent. of ophthalmia.

Considerable importance has been attached by K. Menge (20) to the acidity of the normal vaginal secretion, known to be replaced during menstruation and child-bed by a copious alkaline discharge, in which pathogenic micro-organisms find a suitable habitat. Döderlein has suggested the prophylactic use of lactic acid under such circumstances as a means of restoring the normal acidity of the secretion.

The careful cleansing of the pudenda of parturient women by a suitable antiseptic lotion, as sublimate or lysol, will obviously tend to reduce the likelihood of ophthalmia in the baby. It should never be

neglected.

(2) Prophylaxis in the baby.—It cannot be doubted that preventive measures are more likely to succeed when carried out in the baby than in the mother. We have here a choice of methods, namely, the aseptic and the antiseptic. The aseptic plan is distinguished by its extreme simplicity. It merely requires that the skin of the eyelids and the lashes be freed from adherent secretions by repeated wipings with morsels of damp absorbent wool as soon as the head is born. The figures are quite conclusive as regards the value of these simple means. For example, among 1,000 babies treated in this way, Korn (21) had only three cases of ophthalmia. The offspring even of mothers who suffered from granular vaginitis or other evidences of gonorrhoal infection remained free from ophthalmia. Simeon Snell's experiences (22) were much to the same effect. During a period of three years, 2,242 labours took place in the Jessop Hospital for Women, Sheffield. In the first 200 labours there were a few cases of ophthalmia, but in the last 2,000 not a single case occurred. The antiseptic plan of prophylaxis consists in dropping some chemical agent in the eyes as soon as maybe after birth, in order to destroy any infective material that may already have gained admission. The type of all such agents is the 2 per cent. silver nitrate recommended, in 1881, by Professor Karl S. F. Credé, of Leipzig (11). As soon as possible after birth the baby's eyelids were gently separated by an assistant, and a single drop of the silver was placed in each eye. Nothing further was done. Babies treated by these means collectively remained free from ophthalmia, despite the fact that many of the mothers manifested vaginal blennorrhea and trachomatous colpitis. During a period of nearly three years, 1,160 babies were born alive, and amongst that number one case (at most two cases) of ophthalmia occurred. Large collective figures dealing with the Credé method have been published by several writers, as Haab (23), Köstlin (24), and myself (6). These testify in the most striking way to the success of the Credé plan. The figures are included in the following table:-

	No of Live Births.	Percentage of Ophthalmics	
I. Haab (1886)	. 10,521		1.0
2. Köstlin (1898)	. 24,724		0.655
3. Stephenson (1907) .	. 51,728		0.751

Strenuous objections have been raised to anything like a general adoption of the Credé plan, usually from sentimental reasons. The more tangible objections are three in number:—(1) Conjunctival catarrh; (2) conjunctival hæmorrhage; and (3) corneal opacities or ulcerations. The truth of the matter seems to be that the plan is harmless except for the fact that it is often, perhaps generally, followed by temporary con-

junctival reaction, called by the Germans argentumkatarrh. The reaction, as Credé himself pointed out, is more pronounced in premature than in term infants. Cramer's bad results (25) have not been confirmed, and there is, indeed, a large body of evidence directly opposed to his experiences.

Does the use of the Credé plan invariably prevent the development of ophthalmia? No! It cannot protect against ante-partum infection, nor against infection after the drops have been put into the eyes. A great deal, too, depends upon the way the silver is used, a point on which G. Leopold (26) has laid great stress. All this will be admitted by every impartial observer. At the same time I am convinced that Dr. Peter Horrocks's recent statement (18), which was to the effect that "where there is a gonorrhoea in the mother a single application of a germicidal solution used as a routine measure will not prevent ophthalmia," is far too absolute. It would be interesting to know the evidence upon which so sweeping a statement is made. Such facts as I know of all point in the other direction. For instance, among 816 babies treated by the Credé plan by Zweifel (27), two alone developed ophthalmia, although 61 of the mothers were known to be affected with gonorrhoza. There would be no difficulty in quoting other figures that tell substantially the same tale.

Many attempts have been made to find some anti-

septic agent that would be as efficient as, but less irritating than, the 2 per cent. Credé solution. There is now a practical unanimity of opinion among those best qualified to judge, both in England and America, that in a 1 per cent. solution of silver nitrate we have such a remedy. Among 18,393 babies treated with the 1 per cent. solution, the morbidity of ophthalmia was o.628 per cent.—that is to say, slightly lower than when the Credé solution was employed. It is to be remarked, however, that the latter was used in a much larger number of babies (51,728). But the figures are large enough to exclude any serious statistical fallacy. As matters stand, there need now, in my opinion, be no hesitation in substituting the r per cent. for the 2

per cent. solution of silver nitrate.

To sum up the gist of my remarks on ophthalmia neonatorum, I would say:—

(1) That all cases of ophthalmia in the baby are

due to the direct or indirect transference of infective secretion from the mother to the child.

(2) That such transference may be primary, at or about the time of birth, or secondary, some days or longer after birth.

(3) That gonococci are present, and can be demonstrated in about two-thirds of all cases of ophthalmia

(4) That the causal micro-organisms of ophthalmia, be they gonococci or not, can be found in the female genitals and the male urethra.

- (5) That acute gonorrhœa is not common in the mothers of ophthalmic babies, the underlying infective condition usually being a latent gonorrhœa.
- (6) That some form of prophylaxis should be adopted in every case where a woman in labour is attended by a medical man or midwife.
- (7) That a r per cent. solution of silver nitrate is an efficient and relatively non-irritating antiseptic, for use to babies' eves.

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### CLINICAL RECORDS.

### TWO CASES OF APPENDICITIS.

BY JOHN ALLAN, M.D.EDIN. APPENDICITIS is nowadays a comparatively common

disease, and is undoubtedly more frequently met with than formerly. From a study of the medical and surgical records of our predecessors, one cannot but conclude that the disease presents in our time a more virulent type, and that the assistance of the surgeon has become a matter of greater necessity. The following two cases are instructive, and not without interest.

CASE I was that of W. T———, a man, æt. 47. Case I was that of W. T——, a man, æt. 47. The history was that nine days before his admission to hospital he was attacked with sickness and vomiting, and he suffered from general abdominal pain, which later became localised in the right iliac region. After a few days these acuter symptoms apparently subsided. The bowels, however, remained confined, and aperients, enemas, etc., were tried without avail. Three days before his admission to hospital vomiting again started, was frequent, and finally became fæculent in character. The abdomen became enorfæculent in character. The abdomen became enor-mously distended. Nine days after the commencement of the first symptoms he was persuaded to go to hosof the first symptoms he was possible to a.m. He was pital. He was admitted about 10 a.m. He was brought to the hospital in a cab, and on the way he with severe abdominal pain. On had been seized with severe abdominal pain. On admission he still complained of the pain (the acuteness of which had considerably diminished); his pulse was imperceptible, his respirations were rapid, his face and extremities were cold, and he was covered with a cold, clammy sweat. After being in bed for a little over an hour, he had improved somewhat. His pulse was 140 per minute, but very feeble; respira-tions, 50 per minute; and the temperature was 97° F. The tongue was furred and dirty, the mouth parched, and the breath very foul. The abdomen was distended and tympanitic, and he was bringing up mouthfuls of fæcal vomit very frequently. After rallying, the patient felt quite happy, and laughed and talked with his friends, and he had no conception that he was in a very serious condition. In the afternoon, about 3.30, the rally was thought to have reached its acme, and it was considered that the time for operation (if any was to be done), was then the most favourable that one could expect. The abdomen was therefore opened, and the condition found was dreadful. The appendix was gangrenous, and the gangrene had spread, the cacum to the extent of about three inches being also involved. Close to the base of the appendix the cacum had given way (probably in the morning, when the patient was going to hospital in the cab), and faces were passing into the abdominal cavity. There was enormous distension of the gut, but there was no actual peritonitis. Resection of the gangrenous areas plus anastomosis was out of the question, owing to the patient's condition. Indeed, as soon as the

patient was sufficiently under the anæsthetic to allow the surgeon to proceed with the preliminary steps, it became necessary to dissect out the median basilic vein and give normal saline intravenously. The gangrenous portion was rapidly excised, and the ends quickly sutured to the abdominal wall, after the fashion of a colostomy. The abdominal cavity was washed out with normal saline, drainage established, and the wound speedily closed. The patient soon recovered from the effects of the anæsthetic, and he recognised his relations and maintained a happy attitude to the end, which came about 8.30 p.m.

CASE 2 was that of Mrs P--, a woman, æt. 41. The history was that two days prior to her admission to hospital, she was seized with abdominal pain, etc., the symptoms pointing to an acute attack of appendi-The medical man called in had ordered sulphate of magnesia, and after the administration of this the bowels acted well. On admission she complained of pain (not very severe) over the appendix region. There was slight tenderness on pressure, with some resistance on palpation, over the right iliac area. The pulse rate was 100 per minute, and the temperature was 99.40 As no morphia had been given, the clinical symptoms did not give one the impression of any very serious mischief, only the patient's facial expression was not quite in accord with a mild attack. It was decided to wait until the next day, and in the interval a leucocyte count was taken, and this registered 37,400 white cells per cm. At the operation the appendix was found perforated, and there was a small abscess (about halfa-teaspoonful of pus). Convalescence was interfered with by an attack of ether pneumonia, but, so far as the appendix condition was corcerned, it was quite She was discharged five weeks after uninterrupted.

her operation.

On examining the above two cases, there are several points worthy of notice. In Case I we have exemplified an extreme case and one that will rarely be seen, but it well illustrates the danger of leaving cases too long and the grave character of recurrent vomiting, which becomes fæcal. In justice to the medical practitioner in attendance, it should be mentioned that he twice advised the patient to go to hospital, without success, so that the blame was almost entirely the patient's. Vomiting, as an initial symptom, is present in a considerable number of acute appendicitis cases, but it will disappear in about 48 hours in favourable cases. Its persistence, or, still more, its return after having temporarily ceased, should always put one on guard, as this almost certainly means that there is some grave pathological change in the appendix, such as perforation, gangrene, etc. Another unfavourable point in Case I was the complete obstruction of the bowels. Associated with appendicitis there is generally constipation, and not infrequently there is meteorism during the acute attack, but total obstruction from paresis of the gut is only met with when there is grave mischief of the appendix. An interesting point in connection with this case also, was that the pulse was imperceptible for about two hours before death, although the patient retained consciousness and was able to chat and laugh to within half an hour of his death. This failure of the pulse some hours before death is occasionally observed in severe toxæmic conditions.

toxemic conditions.

With regard to Case 2, interest centres round the examination of the blood. Here we have a case, presenting a typical picture of a definite, but not very acute, attack of appendicitis in which an enumeration of the white blood corpuscles gave a clue as to the nature of the attack. I am of opinion that the leucocyte count is, generally speaking, of most value in those cases of appendicitis where there are small deep-seated abscesses, as in such cases it is often impossible to determine by physical examination whether or not there is a collection of pus. In appendicitis where perforation or gangrene of the appendix occurs, and where there are necrotic changes, the rule is that leucocytosis is very marked, and associated with these cases minute abscesses (often not amounting to more than a few drops of pus) are quite commonly found.
The abscesses, though small, are generally very virulent, and provided that the patient is not overwhelmed by the toxic products, the leucocyte increase is enormous. When one realises that the clinical symptoms in such cases are often misleading, it is easily understood why an examination of the blood is so valuable in determining for or against operation.

### OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

TUBERCULOUS PERITONITIS .- MR. PEYTON BEALE operated on a woman, æt. 30, who had been admitted with the following history: For the last three years she had suffered from very acute abdominal pain, which was particularly felt directly she changed from the recumbent to the upright posture. Its origin was evidently intra-abdominal, and when she was lying on her back she was obliged to support the abdomen with both hands and to press it firmly. This she continued to do for five or ten minutes after assuming the erect posture. She had been under the care of Dr. John Wood, of Deal, who had been watching her for a considerable period, and who had absolutely eliminated the possibility of the pain being hysterical. Sometimes the pain remained for some hours in the epigastric region. Beyond some slight dyspeptic symptoms, the patient complained of nothing else. There was no trace of any hernia, nor was the abdomen lax or pendulous. The past history of the patient was unimportant, except that there was a tuberculous family history. The pain worried her so much, and was increasing in secret, that she readily consented to an exploratory operation. When she was under an anæsthetic, a mass about the size of an orange could be felt supposedly behind the stomach, and there was also some thickening and increased resistance in the appendix region. An incision was made to the right of the middle line of the abdomen, and on introducing the hand a mass of enlarged glands was felt at the back of the mesentery, reaching downwards as far as the level of the umbilicus and upwards as far as the diaphragm. The duodenum seemed to be embedded also in them; some were soft, others calcareous. The mesenteric glands were investigated; some were found eniarged, and were like tuberculous glands. There were also structures which seemed like tuberculous glands behind the cæcum, and there was a little clear fluid in the peritoneal cavity. As there was nothing more to be done, the abdomen was closed.

The patient did very well for about a week, and was see from pain. Then a part of the wound opened, free from pain. Then a part of the wound opened, and some greenish yellow pus was discharged. It was supposed that some of the soft abdominal glands had broken down, and so caused the discharge. She did fairly well for some time, but then developed several inflammatory areas on the surface of the abdomen. These, on being opened, were found to be typical tuber-culous "abscesses." They did not heal, but, on the contrary, each one became a tuberculous ulcer with very marked undermined edges. The patient was becoming thinner, and very soon the temperature began to rise, and she had night sweats. Then the abdomen began to enlarge, and she vomited frequently, and it became clear that she had some slight intestinal obstruction. The abdomen was therefore again opened in the middle line, and was found to contain a good deal of thin, yellowish-green fluid, such as is com-monly found in tuberculous peritonitis; there was also some recent lymph amongst and upon the coils of intestine, and a large pocket of fluid below and behind the liver. The abdomen was freely irrigated with hot salt solution, and the patient appeared none the worse

for the operation.

Mr. Beale said that the pain in this case was a curious feature. Such pain was commonly associated with pendulous abdomens, and with ventral and other herniæ, but he had not come across it before in any cases of abdominal tuberculosis. There was no doubt about the pain and its severity. The history of the case after the first operation goes, he thought, to show that the patient's tubercle was kept under control while she was living on the south-east coast, but when she came to London the tubercle gained the upper hand, as shown by the local lesions in the abdominal wall and

by the spread of the disease within the abdomen. He expected that general tuberculosis would supervene very soon, and the prognosis he considered very bad. It was, of course, possible that there was a bacillus coli infection of the glands as well, which might have accounted for their breaking down after the first opera-The abdominal fluid removed at the second operation would be investigated to see if it contained bacillus coli.

FEMORAL HERNIA.—The same surgeon operated on a woman, æt. 70, who had been admitted with acute intestinal obstruction of one week's duration, with fæcal vomiting of two days' duration. The symptoms had come on gradually during the previous week, and absolutely no history of sudden strain or of anything to account for the condition could be obtained, nor had she suffered previously from any similar attack. She had been under the care of a doctor, who had repeatedly examined her without finding anything to account for the obstruction. The vomiting came on about every half-hour or twenty minutes, quite suddenly, and with little or no effort, and the patient was remarkably well considering the completeness of the obstruction. Nothing had been passed by the bowel for six days. On admission the abdomen was slightly distended; no peristalsis was visible, nor could any tumour be felt. It seemed as if the obstruction was in the small intestine rather than in the large, and the symptoms were just such as might be expected in a case of strangulated hernia. The femoral, inguinal, ventral, and all other regions were carefully examined, but the only thing to be felt was some enlargement of the glands in both groins. The patient was anæs-thetised, and a median laparotomy performed. On introducing the hand into the abdominal cavity, the parietes of the cavity were first examined, and when the hand reached the right inguinal region a knuckle of small intestine was immediately felt protruding through the femoral ring. On examining the right groin with the other hand, and making gentle traction on the knuckle of bowel inside the abdomen, it was observed that there was just a slight wrinkling of the skin in the region of the saphenous opening, but even then there was no protrusion or tumour to be felt in that region. By gentle traction upon the bowel by the hand within the abdomen, and by taxis in the groin by the hand outside, together with flexion of the right thigh, the knuckle of intestine was released and was brought outside the abdomen. It was purple in colour, with a very marked constriction, and on its being exposed to the air for a few minutes it became evident that it could be safely returned. The House Surgeon then completed the operation by stitching up the abdominal wound and applying a dressing.

Mr. Beale remarked that this was one of those femoral herniæ in which simply a knuckle of small

intestine was strangulated, only just sufficient to cause complete obstruction; practically none of the mesentery was strangulated. Although the patient was thin, there was no external evidence of a femoral hern a, and its presence could not be ascertained from without even when the groin was examined with the expectation of finding a hernia. The symptoms presented by the case were significant of complete obstruction of the small intestine.

### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD FRIDAY, JANUARY 22ND, 1909.

Dr. PORTER PARKINSON in the Chair.

THE CHAIRMAN showed a case of

RHEUMATOID ARTHRITIS IN A YOUNG CHILD. Dorothy G., æt. 21, began to suffer from swollen and painful joints in June, 1908; the ankles and wrists were first affected, then the knees, elbows, and other joints. There was much pararticular swelling with excess of fluid in the joints. The joints were at times

acutely painful, and the temperature rose occasionally to 103° or 104°. There was much wasting, and the to 103° or 104°. There was much wasting, and the child had a pallid, earthy tint of skin, and appeared to be suffering from a slow toxæmia. There was general enlargement of the lymphatic glands, especially in the The spleen was much enlarged, axillæ and groins. extending four finger-breadths below the costal margin. Over parts of the trunk and legs was a diffuse brown pigmentation resembling that seen in adults suffering from the same disease. The lungs and heart were normal. There was extreme wasting of the muscles of the legs and forearms. Intervals of apyrexia alternated with fever often up to 103° F., or higher, lasting for a week or so, during which the joint pains and swelling, the lymphatic and splenic enlargements, and the cachexia were all much increased.

There has been great improvement during the last six weeks both in the general and local symptoms.

Dr. E. I. Spriggs said that occasionally, on seeing a case for the first time, there seemed to be some difficulty in diagnosis between subacute or chronic rheumatism and rheumatoid arthritis, though that difficulty generally vanished when the case was carefully gone into. Recently he showed, before the Clinical Section, an adult male with true rheumatoid arthritis, who had enlarged glands in the groin, axillæ, and above the elbow; he also had exophthalmic goftre. In the latter disease there was frequently pigmentation, and in chronic infective arthritis in adults. Exophthalmos had also been described in connection with Still's disease, though he had never seen it. The spleen was probably enlarged in children because that organ responded more easily to infective conditions in them than in adults. He mentioned a case like that of Dr. Parkinson's, in which material had been obtained from the joint, but efforts to cultivate a microorganism were fruitless.

Dr. PARKES WEBER asked whether von Pirquet's re-

action for tubercle had been tried?

Dr. PARKINSON, in reply, remarked that Dr. Spriggs' case of rheumatoid arthritis, in which glands were enlarged, was interesting in showing the link between the cases in children and in adults. He did not think the Dr. T. R. Whipham showed a specimen from a

case of

CONGENITAL CYSTIC DISEASE OF THE KIDNEYS, and a skiagram taken during life. Both kidneys were from a male infant, aged 11 months, who was brought up for whooping-cough and found to have an enlarged abdomen with bulging in both flanks and some dilated The masses could be felt symsuperficial veins. metrically situated, and the anterior edges extended from the costal margin to the middle of Poupart's ligament. The tumours were slightly movable, and the percussion note over them was dull. The liver could be felt 14 in. below the costal margin. abdomen had been noticed to be large since birth. The specific gravity of the urine varied from 1005 to 1010. The urine contained a varying amount of albumin, from 1 to 8 per cent. The quantity of urea was from .4 to 1.8 per cent., the total being from 1.05 to 3.12 grammes per diem. The child, who was not greatly troubled by the cough, became rapidly worse. A transient cedema of the hands and feet occurred for a few days, and towards the end the liver became en-larged and some purpuric spots appeared on the trunk. Death was ushered in by convulsions. The kidneys weighed 7½ oz. each. They were uniformly pale and tough, and showed little difference between the cortex and medulla. They were crowded with innumerable cysts, the largest being the size of a very small pea. The pelves The capsules were somewhat adherent. were dilated and contained a deposit of uric acid sand, but the ureters were normal, and there was no obstruction to the flow of urine.

Dr. PARKES WEBER congratulated Dr. Whipham on having diagnosed the condition during life. In his opinion however, congenital cystic disease was not the only disease which might give rise to enlargement of both kidneys and albuminous urine in a child. He had published a case which showed diffuse lymphocytic growth of both kidneys.

Dr. ROBERT HUTCHISON asked whether congenital

cystic kidneys were ever unilateral, as he had made such a diagnosis in an adult case. He could recall two other cases in which the diagnosis was made during life. If a nodulated tumour could be felt in both loins, and there was suspicious urine, he thought the diagnosis was justified.

Dr. CAUTLEY said he thought the diagnosis could be

justified if only one kidney was felt, as there were several cases on record in which one kidney showed signs and the other was found post-mortem to be also

cystic.
Dr. Forsyth quoted a case in which two enormous cystic kidneys were found post-mortem, but only one had been felt.

Dr. Jex-Blake showed a case of "Fibrosis of the Left Lung," of considerable standing, in a child, æt. 8. There was a history of phthisis on both sides of the family. The patient had whooping-cough at 12 months, and "pneumonia" at 4; no other illnesses. At 5 he was admitted in April, 1906, to St. George's Hospital with fibrosis of the left upper lobe and bronchitis: while in hospital he showed irregular fever, 99°—101° every evening. In January, 1908, he was admitted to the Victoria Hospital with the complaint of cough and wasting: the signs of fibrosis Dr. JEX-BLAKE showed a case of "Fibrosis of the complaint of cough and wasting; the signs of fibrosis at the left apex were more marked, and there was slight clubbing of the finger tips. While in hospital he coughed little, and no sputum could be collected; the temperature was irregular, rising occasionally to 99°—100°.

On January 12th, 1909, he was brought to the hospital again, with a history of cough and general illness

for one week.

No sputum had been obtained since he had been in

hospital.

The X-ray examination shows general opacity of the upper part of the left lung; the heart is drawn over to the left; the diaphragm is low, and moves poorly on both sides. The chief point of interest about this case is that on admission it showed Grocco's para-vertebral triangle of dulness on the right side behind. The CHAIRMAN asked the opinion of members on the

value of Grocco's triangular dulness. He believed the sign to be present in this case, but some had said that it was present in every child, whether healthy or diseased.

Dr. EWART said that in his hands the Grocco sign had been valuable as a sign of fluid, but it was, of course, necessary to exclude the presence of dulness from consolidation. The crucial test was to change the position of the patient, and if the fluid was free the triangle of dulness should disappear, and should return on restoring the body to the former position. Empyemata, not being commonly free, did not answer to this test. When fluid filled the peritoneal cavity and raised the diaphragm, Grocco's sign could be found as a big equilateral triangle bisected by the

Dr. David Forsyth read a paper on

INFANT MORTALITY AS SEEN IN A CHILDREN'S HOSPITAL, a full abstract of which will be found in another column under the heading of "Original Papers."

In the discussion that followed.

The CHAIRMAN said the Section was much indebted to Dr. Forsyth. He commented on the few deaths attributed to rickets, due to the deaths from rickets being put under the heading of the terminal trouble, whatever it might be.

Dr. DUDFIELD said that Dr. Forsyth had shown a classification of deaths on a strictly scientific principle, which could not be said for the Registrar-General's classification. The Registrar-General's rule that if the duration of the disease was not mentioned on the death certificate, the first disease on the list should be taken as the cause of death, led to some curious results. For instance, syncope would be mentioned first and diabetes second. In a case of broncho-pneumonia or tubercle and whooping-cough, whooping-cough was usually selected for the cause of death. Marasmus was a very favourite term with the profession.

Dr. HUTCHISON expressed surprise that mastoid disease was responsible for 3 per cent. of the deaths. He did not think that this would be found to be the case at the Great Ormond Street Hospital. Might it be due to the large amount of whooping-cough treated at the Evelina?

Dr. Meredith Richards said that marasmic children admitted to hospital would have proper treatment, and many of them recover, whereas if they were not admitted to hospital death was more likely to occur. In tubercle also, there was a large amount of selection. Therefore it is necessary to take precautions when comparing hospital figures with those gleaned from the community in general.

Dr. W. EWART said that a post-morter, basis seemed to be the only reliable scientific one. The difference in statistics from a hospital and those from sources remote from hospitals was an index of the progress of medical science.

Dr. CAUTLEY congratulated Dr Forsyth on his energy in regard to the paper, but the conditions of hospital practice were so different from those in everyday life that he doubted the applicability of the results. He would have liked to have known the ages or the mean age of the cases.

Dr. FORSYTH, in reply, said that it was from the scientific aspect that he regarded the figures. The methods adopted in tabulating death registration were different from those in a hospital. He understood from Dr. Dudfield that if a child died from septic meningitis or mastoid disease twelve months after having suffered from scarlet fever, the death was attributed to scarlet fever. That was misleading. Another point was that his statistics were taken over a period of twenty-three years. Twenty-three years ago the deathrate from mastoid disease was probably much higher than now, and no doubt now it was less than 3 per cent. He had tried to show that a diagnosis on clinical data was not always a true one, post-mortem examinations giving the most accurate figures.

### ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, JANUARY 15TH, 1909.

The President, Dr. W. G. SMITH, in the Chair.

NOTES ON A YEAR'S MENTAL HOSPITAL WORK.

Dr. Dawson read a short report of the more interest.

DR. DAWSON read a short report of the more interesting points which had arisen in the practice of Farnham House Mental Hospital during the year ending March 31st, 1908. Of the admissions the essential cause in 29.4 per cent. was diathesis, in 47 per cent. various forms of moral and physical wear and tear, and in 23.5 per cent. toxic influences. There was, however, a neuropathic heredity in 71.4 per cent. The forms of disease in the cases due chiefly to diathesis were mania, melancholia, and dementia, with two cases of alcoholism. In one of the cases belonging to the second class the cause appeared to have been relief of anxiety. Of the toxic cases, one of alcoholic paranoia was quoted as showing that some alcoholic cases exhibit no symptoms pathognomonic of their origin. A case of true diabetic melancholia was also detailed, which recovered mentally when the sugar disappeared. Amongst the admissions melancholia had been the prevailing form of disease. As regards physical signs, albuminuria had been found in 12 cases, mostly of a depressed cast; glycosuria in 8. Arterial pressure was tested in 7 admissions, being found normal in 2, high in 5. A case was detailed which seemed to show that large doses of bromide may possibly lower resistance to micro-organisms. Thyroid treatment was tried in 7 cases, with good results in 3.

Two, however, were not improved, and the state of the heart induced by the drug had given some anxiety for a time. Atropin treatment had been used in 2 cases of alcoholism with some immediate success; unsuccessfully in a case of morphinism. Suprarenal had been found useful in keeping excitement in check. Some advantage had been found in the use of formates and lecithin.

The PRESIDENT said that, to the ordinary practitioner, the subject of ætiology, on which Dr. Dawson

had dwelt at the commencement of his paper, was, perhaps, the most important chapter in neurological If their minds were clear as to the circumstances that predisposed to insanity, the practitioner might sometimes be in a better position to forewarn patients, and be forearmed himself as to what to do.
The discussion in that Section last year had showed that the influence of alcoholism per se in the production of insanity had been over-rated. He was anxious to know if there were any definite mental variations correlated in any way with the forms of alcoholism. It was said that the police of France found absinthe drunkards to be homicidal, and had to separate them from the others, and it was possible that the essential oils in absinthe were important in producing pathological results. He would also like to know if there was any particular type of mind, or mental development, that was specially predisposed to alcoholic disturbance.

Dr. KIRKPATRICK thought that in two of the three groups of causation—diathesis and mental stress and strain—it was difficult to appreciate Dr. Dawson's exact meaning. He had some difficulty in understanding what he meant by regarding diathesis apart from heredity in some of his figures. Did he recognise a type of individual who was likely to go mad apart from any hereditary taint? He thought there was a difficulty in accepting mental stress and strain as a general cause of insanity, although it might be a predisposing cause in conjunction with some weakness, hereditary or acquired. It had been proved that eyestrain, either from want of muscle balance or errors of refraction, was capable of producing very serious nervous troubles, and many long-standing nervous diseases had been cured by correction of such errors, which might be a cause of trouble in the brain, and, under subsequent strain, might produce; insanity.

under subsequent strain, might produce insanity.

Dr. Dawson, in reply: The correlation of alcoholism and mental affection did not appear, as far as he was aware, to have been studied. He was strongly of opinion that anyone who had a neurotic heredity, or who had acquired it, should abstain absolutely from alcohol, as all such were liable to go to excess. Melancholic and demented patients were liable to suffer more from glycosuria than others. There were very few cases of insanity in which there were not contributory and exciting causes, and his classification was only intended to embrace what he considered the predominating cause of the particular attack. Diathesis was probably always hereditary, but it was not possible in all cases to trace the heredity. A widespread peculiarity, too trivial to excite any great remark, would produce a greater effect in the offspring than the occurrence in a family of a few sporadic attacks of insanity. He therefore held diathesis to be a different thing from heredity. He had not had experience of cases due to eye-strain.

INTRACRANIAL TUMOUR.

Dr. Drury read the history of a case of the above disease in a female, æt. 30. Her symptoms had lasted for six months before she came under observation. When seen, the cardinal symptoms of brain tumour were present, but there was nothing to indicate its position. As she was getting rapidly worse, unconsciousness impending, and sight almost gone, it was decided to ask Dr. Arthur Ball to do an operation for the relief of pressure. This was done on July 13th. A large trephine opening was made in the temporal region on the right side under the muscle; the dura opened, and a small quantity of fluid escaped; the wound then closed. Improvement followed rapidly; at intervals vomiting and headache returned, and the brain was tapped, fluid being drawn off on each occasion. These intervals became shorter, till eventually tapping had to be done daily. A tube was then inserted and kept in permanently for several weeks. During all this time very large quantities of fluid escaped. She improved so much that she could walk about, and could see and recognise people, and had nout, and could see and recognise people, and had about, and could see and recognise people, and had nouther headache nor vomiting. The wound was kept aseptic during the whole time. She suddenly became unconscious one morning and died the next morning, November 8th, nearly five months after operation. The case was brought forward to illustrate the merciful relief afforded by an operation of this kind, where

there were no symptoms to indicate the position of the lesion, and, therefore, where no operation with any hope of cure could be attempted. It was found that the lesion was a large cyst in the cerebellar and pontine regions, which could not have been dealt with even had it been localised.

NOTE ON POLIOMYELITIS OF THE CONUS MEDULLARIS. Dr. O'CARROLL read an account of a case of the above condition. A girl, æt. 17, had been sent up from the country suffering from "tumour of the bowel." This turned out to be a very big prolapse of the rectum. Some months previously she had had a febrile attack, following which she had suffered from incontinence of urine and fæces. Later the bowel prolapsed. The sphincter ani was entirely relaxed, and the opening of the urethra rather wide. Sensation was perfect. The the urethra rather wide. Sensation was perfect. The patient's general health was good. Under treatment, principally by the Faradic current, complete control was recovered in the rectum, but the patient was unable to retain urine for more than two hours when she left hospital.

#### OPHTHALMOLOGICAL SOCIETY UNITED KINGDOM. SOCIETY OF THE

MEETING HELD IN THE ROOMS OF THE MEDICAL SOCIETY OF LONDON, THURSDAY, JANUARY 28TH, 1909.

The President, Mr. R. MARCUS GUNN, in the Chair.

MR. A. W. ORMOND showed a case of tubercle of the choroid, and Mr. DOYNE a case showing peculiar opacities of the cornea.

Mr. BISHOP HARMAN read a paper on FOUR GENERATIONS OF LAMELLAR CATARACTS.

He showed the pedigree of a family for five generations, four of which presented a marked inheritance of congenital cataract. Seventeen childships were traced, comprising 63 persons; 8 died in infancy. Of the remaining 55, it was known that 19 had congenital cataract. In no case had there been any in-breeding or marriage with a person similarly affected. of cataract was, for the most part, central opacities of varying size; some were minute, Y, or X, or starshaped; others showed definite lamellar formation. In some cases the cataracts were of long standing, and no evidence could be found that they had progressed beyond the stage at which they were earlier seen. Probably the number of cases of cataract found did not represent the true total, for in one childship of seven members, amongst whom only one case of cataract was admitted, examination of the seven showed that four had lenticular opacities. The inheritance was strictly from those who had cataract; in no case was cataract found in a child where the parents were free from the defect. When a defect had disappeared from a branch of the family, it did not tend to reappear. The teeth usually were good, and no other developmental errors were found.

Mr. HARMAN also read notes of a case of unusually

RAPID DEVELOPMENT OF CATARACTS in a boy, æt. 9. A year previously his vision had been recorded at school as 6/18; an examination passed three months before showed that he could then write When seen he was quite blind; both lenses were completely cataractous; the lens matter was soft and opaque. The lenses were removed by curette evacua-tion at the Belgrave Hospital, and at the end of six weeks the boy left the hospital able to read 6/18 with cataract glasses, and later on he saw 6/6. He showed no trace of general disease, but there was some evidence

of defect in his ciliary vessels.

Mr. A. S. Percival (Newcastle) read a paper entitled NOTE ON THE COLOURS OF BENHAM'S TOP,

and he demonstrated the different colours shown when the top was rotated clockwise, as compared with those when the rotation was in the opposite direction. explanation, which was not yet certain, was highly technical, and he suggested several theories.

Mr. Percival also read a contribution on some RHYTHMIC OSCILLATIONS OF THE PUPIL.

He said that all were familiar with the rhythmic contraction and dilatation seen in certain diseases, and which were usually looked upon as of grave signifi-

cance. He compared this with the oscillatory discharge from a Leyden jar, which occurred under certain conditions. If it were discharged through a conductor of high resistance, the charge simply died away. If it were discharged through a good conductor, such as a coil of wire, the discharge consisted of a number of excessively rapid oscillations or surgings. He then compared the nerve cell and axis-cylinder with the Leyden jar and conducting wire, stating that, owing to disease, the discharge of nerve impulse was made in an irregular manner. He regarded the movement-tremors of disseminated sclerosis as an almost exact parallel to the oscillatory discharge of a Leyden jar.
Mr. David J. Wood (Cape Town) sent a communica-

tion on a case of

RETINAL EXUDATION WITH EXTREME DISTENSION OF

VESSELS, and perhaps arterio-venous anastomosis. He reminded members that he had contributed a similar case to the twelfth volume, and another to the twenty-fifth, and recently he had seen and examined a third instance of this rare condition. He saw the patient first in 1902, and ordered glasses for her; there was then no com-plaint of sight being bad. Later, as she had an attack of dimness of vision, he examined her fundi, and found large blood-vessels running up to a patch on the upper part of the fundus, which possibly might have resulted from a former hæmorrhage. The patient, who was then 50 years of age, returned in 1907, reporting that a few days previously the right eye had suddenly failed. He found that to be due to a diffuse opacity in the vitreous; no fundus details could be made out. Then the vitreous began to clear, and the drawing he showed presented a picture of the appearance. There was a white area above, and enormously dilated blood-vessels could be seen running up to it from the disc. The colour of the vessels, which were very tortuous, was intermediate between that of arteries and veins. From the left trunk a vessel sprang which was arterial in colour, while another vessel, obviously venous, sprang from the opposite main trunk. There were fine choroido-retinal changes, which covered the inner part of the fundus. thought the growth was probably surcomatous, and his colleague advised excision, but the author was so impressed with its likeness to his other cases that he held his hand. He hoped to report further on the case. He had not been able to hear more of his second case, already mentioned.

Mr. TREACHER COLLINS described a similar case, and remarked on the rarity of the condition; and Mr. G. COATS described the pathological findings in a case

he had thoroughly examined.

### CORRESPONDENCE.

### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

### FRANCE.

Paris, Jan. 31st, 1909.

LEPROSY IN FRANCE.

MANY persons live under the impression that leprosy belongs to another age and that it has disappeared from the surface of the earth for centuries. Such is not the case, unfortunately. It is to be met with in abundance in Europe, and more especially in Norway, where there are at present somewhat over 500 lepers treated in the hospitals or leprosaries: Bergen, Molde, and Trondhjen.

Russia possesses two important centres: the Baltic and Finland on the one hand, and the provinces shores of the Black Sea, the Caucasus, and the neighbourhood of the Caspian Sea on the other.

The Balkan peninsula is the most contaminated of the European regions, while 600 lepers may be counted at Constantinople, Greece, Montenegro mania also furnish a certain contingent. and Rou-

In Asia, the principal centre of leprosy is Hindustan, where there are over 130,000 lepers out of 200,000,000 inhabitants. A large number is also found in Central America.

In France there exists a popular belief that with the edict of Louis XIV. (August 24th, 1693) which suppressed leper hospitals in the country, all trace of the dire disease had disappeared.

The truth is that leprosy can be found in France under two forms: a typical and modified form.

According to Dr. Zambaco, who made a special study of the malady in its two characters, the modified form is very frequent in France, but passes under other names as new maladies: Morvain's disease, syringomyelia, sclero-dactylia, gangrene of the extremities, etc.

According to Professor Milian, the above form of leprosy can be met with not only in Brittany, but also along the shores of the Mediterranean.

THYROID INSUFFICIENCY. There are few problems in the domain of general physiology which have excited so much research and controversy as the rôle of the para-thyroidian apparatus, since Reverdin published several cases of myxœdema provoked by surgical extirpation of the gland.

As is well known, the apparatus is composed of the thyroid gland proper and four little glands; two external, situated on the posterior surface of the gland, and two internal included in the corresponding lobes. All these glands possess an internal secretion

as they are deprived of excreting canals.

The structure of thyroid gland differs from that of the satellites, and consequently they play a different rôle in the economy. Experimental research proves that the thyroid body regulates nutrition, while the small glands have principally to defend the economy against poisons elaborated by the organism.

It is needless to mention in detail the accidents resulting from the absence or atrophy of these organs, which in children result in cretinism, and in adults in obesity, somnolence, apathy, impaired memory and intelligence, dry, wrinkled skin, cyanosed extremities, low temperature, sensation of cold, etc.

But less known, perhaps, are the symptoms of insufficiency. Where this insufficiency is well marked, the diagnosis is easy, but when it is slight it is manifested by little signs which frequently pass unobserved. Drs. Rothschild and Levi have conjointly published a paper on this subject in which are enumerated all these signs that command attention.

Transitory Edema.—This cedema, white and indulent in character, but which has nothing in common with albuminuria, is found seated over the eyelids, the frontal region and the malar bones and anklus. It is generally intermittent and is provoked by fatigue, migraine, etc.

Eyebrow.—The external third of the eyebrow de-

prived of hair is very frequently seen in persons suffering from slight insufficiency, due to some trophic trouble or to a kind of keratosis of the piliary follicles (Hertoghe).

Sensation of Cold.—The thyroid body, having a thermogenic function, quite a series of disturbances in the calorification of the organism result from its derangement: cold extremities, sensation of dead finger, shivering running through the body, especially in the dorsal region, at certain moments of the day, between four and five o'clock in the evening; central temperature below the normal, predisposing to extreme sensitiveness to cold. The slightest draught provokes in these persons rheumatic pains, neuralgia,

lumbago, migraines, coryza, tonsillitis, etc.

Fatigue.—Patients of the above type complain
easily of lassitude, and, as remarked Hertoghe, this
feeling of weariness is frequently observed in the morning.

Headache.—Cephalalgia is more intense in the morning, but disappears towards the afternoon after a good repast. The patients are so accustomed to this continual headache that they hardly speak of it.

Obssity.—Thyroid insufficiency is frequently accompanied by embon point, if not absolute obesity, constituting, according to Mr. Hubierge, a modified form of myxædema. In women, the menses are observed to be too frequent, too abundant, or too prolonged. Such are the symptoms observed in adults. In chil-

dren where the thyroid insufficiency is well marked, the mental and physical conditions are very backward, while nanism, cretinism, myxædema are the rule. Where the insufficiency is slight, the patients are undeveloped, the intellect somewhat obscured, and puberty retarded. The rational treatment of all these conditions is that by thyroid extracts, of which there are several preparations in the market.

GERMANY.

Berlin, Jan. 31st, 1909. AT the Verein für Innere Medizin, Hr. Ludwig Meyer introduced a discussion with a paper on

EXPERIMENTAL INVESTIGATIONS INTO ALIMENTARY FEVER.

He remarked, by way of introduction, that it was recognised that large doses of common salt introduced into the alimentary canal acted as a poison, both in animals and the human subject. With sufficiently large doses death took place in a few hours by means of purely physical processes. Many symptoms coming on after such large doses had been described, but the heightened body temperature caused by it had only lately come under observation in the city Kinder-

The speaker approached three questions experimentally: (1) In what degree of concentration does salt act pyretogenically? (2) What are the behaviours of healthy and unhealthy infants in regard to such concentration? (3) Is the pyretogenic action the pro-

Young infants were given 100 grm. of a correspondingly dosed solution twice, the periods separated by intervals of two hours. General disturbances were never observed. At first strong concentrations of saline solution were tried. Concentrations of salt of 3 to 100, in 11 cases, mostly healthy infants, always caused fever, in part the temperature remained subfebrile, in part high fever was produced (39 and 40° C.).

The course of the heightened temperature was always the same: Rise after 2 hours, the acme after 6 hours, the fall to normal after 12 to 24 hours. The speaker spoke of the fever—after excluding bacterial and inflammatory causes—as directly or indirectly due to the salt.

Reduction of the concentration to the physiological degree (0.75) in doses of 100 grm., never caused alteration of the body heat either in infants suffering from alimentary disturbances, or in healthy ones. A considerable increase of the quantity given caused a rise of temperature in infants suffering from disturbances of nutrition, but not in healthy ones. These differences between healthy infants were more marked when stronger solutions were made use of (1 per cent.). With this those infants, almost exclusively, that were suffering from acute intestinal disturbances, reacted with a rise of temperature. An important part must therefore, be attributed to the intestinal walls and to the intestinal epithelium in cases of poisoning with hypertonic solutions of salt. If this pyretogenic action of salt solutions was due solely to processes of a physico-chemical nature, solutions of other salts which were iso-osmotic with 1 per cent. solutions of common salt must set up a similar effect. That was not the case, however, a 3 per cent. solution of potassic iodide did not alter the temperature at all.

The pyretogenic action was therefore a specific one; which part of molecules of ClNa was the carrier must be analysed. Other iso-osmotic combinations (KCl) were also without any influence on the temperature, and other Kations K and Ca combinations, KBrm, KPHO<sub>4</sub>, CaCl<sub>2</sub>, had just as little power of raising the temperature.

The fever action was, therefore, exclusively associated with the Kation Na. But not all the Na combinations produced similar effects. The speaker divided them into apyretogenic and pyretogenic groups. The speaker To the first belonged sod. sulph., sod. lact., sod. acet., sod. salicyl., sod. bicarb., and to the latter sod. brom., sod, iodat., and this caused a rise of temperature exactly similar to that caused by the sodium chloride.

In looking over the histories of cases of poisoning by salt, and making a comparison with the cases produced experimentally, he was inclined to the opinion that the poisoning was due to the rapid absorption of these particular combinations.

Hr. Rosenheim was moved by the address to think of the idiosyncrasies not unfrequently met with as cases of fever set up by food. He recalled a case of the kind, that of a girl of 12, who suffered from fever for 15 months—sometimes very high—in connection with acute indigestion. All treatment was powerless, and the little patient became much prostrated. By a radical change of diet the fever was removed in two days. She had been given a diet in which eggs and meat juices played a considerable part, and these were now left out. Some time afterwards they were again introduced and the fever returned in a severe form. He had seen three similar cases; two of the patients were women who had had influenza with diarrhœa. Although improvement took place, the patients felt very weak and the temperature rose in the evening. In these cases the high temperature remained even when the diet was changed. The third case was that of the son of a medical friend. The boy became very feverish from an error of diet; the intestinal catarrh improved, but the fever persisted, so that he was sent to a hydropathic establishment, where improvement took place. Afterwards, however, fever came on regularly in the evening, against which no change of diet was of service. This condition had lasted 21 months when the speaker first saw the patient. Here, also, a radical change of diet caused a striking change of condition. No bacteria were found in the stools.

Hr. Brugsch remarked that the intravenous injection

of salt set up fever.

Hr. Albu looked on salt fever as a kind of autointoxication. The intestinal epithelium was not sufficiently active. There were cases in practice where the fever could not be traced to any error of diet, but was simply due to intoxication from imperfect action of the intestines. Alimentary fever was of local origin.

### AUSTRIA.

:Vienna, Jan. 31st, 1909.

MORPHIA POISONING.

At the Gesellschaft, Lehndorff recorded the case of a child, 7 weeks old, that suffered from morphinism, induced by using a suppository. The child became cyanotic; temperature, 33° C., or 92° F., with slow pulse and respiration. The pupils were like pinheads, reflex greatly exalted, while the child had all the appearance of larynx stenosis, which was relieved by intubation.

Knopfelmacher said that he had recently met with a similar case of poisoning, with cramps and laryngeal spasm. He also observed that this poisoning was not uncommon with codeia, as well as tincture of opium. Such cases can only be treated with expectants, as recovery is always doubtful. At this stage Knopfelmacher showed a case of chronic congenital hydrocephalus. The cranium measured 68 ctms., and the reflex was greatly exalted. He had performed 88 lumbar punctures, which seemed to inhibit the increase of the hydrocephalus.

CHRONIC TETANY.

Escherich showed a child, 13 months old, who, since the third month, had typical tetanic contractions associated with the facial phenomena and excited with the electric stimuli. There was no rachitis present, and Escherich attributed the disease to the insufficiency of the epithelium bodies in the thyroid. With this object in view, his therapeutic treatment was directed to implementation of more epithelial bodies in the gland, which we hope to hear more of in the future.

Fleishmann gave a brief account of his experiments in congenital tetany, attributed to hypoplasia of the enamel of the teeth. He had met with seven cases where chronic tetany was present, associated with hypoplasia of the enamel, which probably depended primarily on the insufficiency of the epithelial bodies.

the insufficiency of the epithelial bodies.

Erdheim had found that the same condition produced a stunting of the growth of the teeth, as well

as ectoderma of the body. One particular condition in connection with tetany may be mentioned, that it mostly appears in the second half-year of life. Neurath remarked that ectodermal formations were not confired to tetany as they appeared in other diseases where development was disturbed; for example, in typhus the hair fell out; in scarlet fever the nails became ribbed, etc.

ACUTE BULBAR PARALYSIS.

Popper presented a boy, æt. 6, with acute bulbar paralysis, which had for its origin poliomyelitis. At one time the paralysis seemed to recede, and the cerebral ataxia as well as the nystagmus improved. Hitherto the unsteady gait, weakness of the facialis, and paralysis of the ocular muscles were absent, as well as the paralysis of the extremities.

Tuberculosis as an Infantile Disease. Hamburger read a paper on tuberculosis as a disease of childhood, although he held that puberty and advancing years see an outbreak of the latent centres in the form of pulmonary phthisis, which is only another manifestation of a latent centre of tubercle. The exacerbation is only a removal of the infection from the old centre to some new point, and hence it becomes auto-infectious. It is one of the peculiarities of phthisis that tuberculosis flourishes best in a tubercular organism, and thus phthisis is always seen as a late form of tubercle. According to anatomical results, the so-called recent tuberculosis of the adult is therefore not a correct description of the form of infection, but is more likely to be implanted in the infant, which is the most important question of the day.

### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

### BELFAST

NOTIFICATION OF BIRTHS ACT.—The first prosecution under this Act in Belfast took place last week, when a midwife who attended a woman in her confinement, and the husband of the woman, were summoned for neglect to notify. The Medical Officer of Health said that the failures to notify births were no less than 30 per cent., and the authorities were determined to prosecute. All medical men in the city had been informed by circular of the coming into force of the Act, but it was impossible so to warn midwives, as they were not registered in Ireland. The midwives had been personally warned, and the midwife who was summoned had been warned three times. It was only through the death of the child that this case came to their notice. The father was discharged, and the midwife was fined 5s. and costs.

NEWTOWNARDS NURSING SOCIETY: ADDRESS BY PROFESSOR LINDSAY.—The sixteenth annual meeting of the Newtownards Nursing Society was held last week, when the Marchioness of Londonderry presided. Professor Lindsay was present, and gave an address on "The Necessary Conditions of a Healthy Community." He laid down ten conditions as essential for a healthy community, as follows:—(1) A suitable site for the town; (2) a stock of average soundness and vigour; (3) healthy houses; (4) a pure and adequate water supply; (5) a suitable food supply; (6) proper sanitation, domestic and urban; (7) the regulation of trades and employments; (8) proper school buildings, and the medical inspection of schools and scholars; (9) temperance; (10) suitable arrangements for the care of the sick, and for the isolation of infectious disease. Professor Lindsay emphasised the point that at least one-quarter of all disease was preventable, and that prevention is not only cheaper, but better than cure.

BELFAST HOSPITAL FOR SICK CHILDREN.—The annual meeting of this hospital was held last week, Bishop Crozier presiding, and moved the adoption of the report. This was seconded by Mr. John Stevenson, Chairman of the Ulster Hospital for Children and Women, who referred to the friendly feeling between the two hospitals and the abundant scope for both on the two sides of the river. The medical staff report was read by Mr. T. S. Kirk. It recorded that the

intern patients numbered 666, the surgical operations 375, and the total attendances at the extern 12,069. Allusion was made in feeling terms to the great loss sustained by the hospital in the death last year of Dr.

Sidney Smyth.

FORSTER GREEN HOSPITAL.—The annual meeting of this hospital was held in Belfast last week, Mr. Herbert Ewart presiding. The work of the hospital was seriously interrupted for several months last year, the hospital being closed for building operations, new wards being added to accommodate the patients who are now sent to the hospital by the Public Health authorities under a special agreement. The new building accommodates 73 patients, and will admit of considerable enlargement if needed. Dr. Thos. Houston read the report of the medical staff, which recorded the treatment of 167 patients in the wards, and 425 new cases in the extern department during the year. Professor Lindsay, who spoke, said that it had been cal-culated that there ought to be one bed for the treatment of tuberculosis for every thousand of the population, which would mean about 4,500 beds for Ireland. There were only about a tenth of this, but, of these, two-thirds were at or near Belfast. Since Ireland two-thirds were at or near Belfast. suffered so much, he thought 4,500 beds was the minimum required, and such could not be provided by charity alone. He referred to the assistance given by the great insurance companies in Germany, who found it paid them to provide treatment in sanatoria for those insured with them.

### LETTERS TO THE EDITOR.

HE EXCLUSION OF IRISH AND SCOTCH DIPLOMATES FROM ENGLISH HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Touching on the question of the exclusion of the holders of Scotch and Irish qualifications from most of the important London and many of the provincial hospital appointments, I am quite of the opinion that it would be well to obliterate those clauses —in the rules which govern the elections to the staffs of hospitals—which have any reference to the diplomas to be held by candidates for such appointments.

I think the obliteration of such clauses would be distinctly, though, perhaps, rarely, in favour of the hospitals, for if no such clauses existed there would be from time to time a candidate elected who does not happen to hold either the diploma of the London College of Surgeons or of the London College of Physicians; but I think there is very little doubt that that candidate would be the best among those applying for the appointment, and that the election would be certainly on the merits of the individual-in fact, the candidate elected would be the man whom the governing body of the hospital would desire to have on their staff, to the exclusion of all the other candidates, notwithstanding the fact that they might hold the diplomas of the London Colleges.

On the other hand, if the clauses referred to were removed, there would be no compulsion on the part of the hospital governing body to elect the candidate who might be Scotch or Irish, and they certainly would not do so unless his greater merits outweighed the merits, plus the possible greater acquaintance and knowledge of the character of one or more of the candidates who might hold the diplomas of the London Colleges.

Therefore, I say that it would be advantageous to the candidates, and also to the hospitals, that these clauses should be removed At the same time, I would urgo that the professional brotherly feeling which would be exhibited by the removal of these clauses should be reciprocated all round—that is, in Scotland

and in Ireland.

Scotch and Irish members of the profession practising in London and the provinces are certainly received by the profession in England absolutely without any distinction. Is it quite the same when vice versa? Can we not recall the time when it was proposed that an English examiner should be associated with . . . examiner at a certain . . . University?
The local journals were outraged, and declared that such an election would be a slur upon the nation. Do we not find other forms of cliqueism where such should not exist? It may be called patriotism, but patriotism which does not extend to the Empire is false, selfish, and degrading.

I am, Sir, yours truly,
A. T. NORTON, C.B., F.R.C.S.

### ANTI-VIVISECTION FANATICISM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-Publication in the Times of the circular issued by an amiable anti-vivisectionist, calling upon supporters of the cause to pray to a merciful God for the "removal" of leading physiologists, and suggesting that prayer had already led to the "dropping" of one eminent man, has been followed by the usual correspondence. The Hon. Mr. Stephen Coleridge is, of course, to the fore. Mr. Coleridge has long ceased to afford pure amusement; he now excites little else than pity. From his point of view he has mastered the vivisection question; from our point of view it has mastered him. In this condition of obsession he is evidently quite unconscious of the unintentional tone of malignancy and hatred which seems to be conveyed through his writings. He, and those of his followers in a similar state of mind, must endure constant misery through contemplation of the horrors of the physiologist's laboratory which are ever present to their imaginations; they are all objects for commiseration. Mr. Bernard Shaw shows, at any rate, by his share in the discussion, that he has not yet quite earned the right to the title of "the British Tolstoy," which, I am told, has been bestowed upon him by some of his followers. His contribution to the Times consists of a brief yet ponderous and laboured joke, quite up to the level one might expect in a "littery gent," but far from good enough to carry the signature of a philosophical, wise, and magnanimous man of letters. These leading anti-vivisectionists and their fellows, luckily, have so far failed to hamper in the least the progress of research in these islands, and as there seems less prospect than ever of their being able to accomplish anything, physiologists can look upon their performances with complacency. If anything were needed to complete the hopelessness of their cause, it might be found in the effusions of paid officers of their societies, which on every occasion are in evidence. Some of these gentlemen are gaining good incomes from their offices. Unless human nature for once has changed, the last thing they can really hope for is the success of the movement for which they are ostensibly working. Once vivisection is put a stop to, their profitable occupation would be gone. Hence, no doubt, the delight of some of them at rushing into print on every opportunity, while cherishing a shrewd suspicion that they are thus helping to postpone the day when the aspirations of their generous paymasters shall be realised.

I am, Sir, yours truly, A SURREY DOCTOR.

Near Reigate, January 27th, 1909.

### INCONTINENCE OF URINE ASSOCIATED WITH EPISPADIAS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The communication by Mr. R. P. Rowlands you publish in THE MEDICAL PRESS AND CIRCULAR of anuary 27th, under the above heading, is most interesting. I am quite in accord with the author that the method employed is original, especially with reference to all the work being external to the mucous membrane, which is not injured. The most important points I consider are—(1) The proof that the nervous supply was sufficient to give control after the small amount of muscular tissue at the neck of the bladder had been joined over the urethra; (2) the ease with which the pubic bodies could be retracted in a boy as old as 6 years, without any interference with the sacroiliac synchondroses. May I ask Mr. Rowlands if he experienced much difficulty in separating the neck of the bladder and the short urethra from the pubic bones, and also from their lateral attachments? I would also like to know if there was any trouble in

re-introducing the catheter after its removal on the fourth day; this evidently must have necessitated the employment of great care in order to avoid disturb-ing the structures which had been joined over the urethra and which, as Mr. Rowlands says, firmly gripped the instrument after the operation. I am certain that all surgeons would be anxious to see in THE MEDICAL PRESS AND CIRCULAR an account of any subsequent operation Mr. Rowlands may undertake on this patient for the correction of the epispadias.

I am, Sir, yours truly,
A LONDON SURGEON

ONE MORE CAUSE OF THE SPREAD OF CONSUMPTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-Few people think, when they lay their heads upon a pillow to take their night's rest, of the danger they run of infection from a pillow which they themselves or others may have rendered by their breath a hot-bed of disease. Of all bedding or bed clothing, none is more liable to do mischief than a pillow, for, beyond the changing of pillow-cases more or less frequently, nothing further is done to lessen the power for ill of the swarms of germs constantly and steadily breathed into the pillow through the night, and it is only due to the power of individual resistance that disease is not more rapidly spread. The power of resisting the invasion of germs being less at night, and the head being in close contact with the pillow, may account for the persistence of many respiratory diseases. Can, therefore, any of your readers suggest an apparatus, simple of construction and easy of use, and sufficiently cheap to be within the reach of the masses, yet capable of effectually sterilising pillows?

I am, Sir, yours truly, ROBT. HUGH HODGSON, M.D.

Peckham, January 27th, 1909.

THE TIMES AND QUACK ADVERTISEMENTS. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the letter which you do me the honour to print to-day, January 27th, I pointed out that many inebriates owe their fall "to trust in one or other of the sham tonics containing alcohol, now so enormously advertised." The Times, in a leader, also, to-day, on "The Care of the Inebriate," expresses more strongly the same opinion in the following passage:-

"Every inebriate, however, passes through an early or preliminary stage; and the time-honoured principle, to oppose beginnings, might in very many cases be applied to him successfully if we would only look facts in the face, and endeavour to educate the public opinion by which, in the opinion of the committee, the Legislature has twice been deterred from accepting the good advice offered for its guidance. In the case of drugs, much might be done by a more strict interpretation and enforcement of the laws against the sale of poisons, and by the absolute prohibition of the many quack medicines, advertised as remedies for various complaints, which owe their popularity to the cocaine, the morphia, or the alcohol which they contain, and to the temporary and delusive sense of comfort which they afford. Preparations of this class are the frequent causes of an ultimate resort to the same agents in

stronger forms; just as the practice of taking irregular drinks at all periods for so-called good-fellowship, or for 'any other reason why,' is a common precursor of habitual intoxication." This affords one more illustration of the fact to which you referred in a recent editorial-namely, that,

in the matter of medical quackery throughout, it is evident that the editor of the *Times* does not know what the manager is doing, and the manager is not cognisant of what the editor is writing. The editor on occasion denounces various systems of quackery, the advertisements of which are freely admitted to his own paper. Surely, if "absolute prohibition" by law of certain advertised quack medicines is called for, the advertisements of these pernicious preparations ought not to be admitted to respectable newspapers. If the editor of the *Times* will look through a recent file of his paper, he may

easily discover plenty of advertisements of this class. If a column of the *Times* costs, as I believe, £20, the size of these advertisements forms a measure both of the total outlay and of the enormous extent to which alcohol, under the mask of sham, harmless tonics is being consumed by the innocent and ignorant public. The appearance of quack advertisements in a paper which denounces quackery must surely help to deceive the ingenuous reader, and make him believe that these announcements at least are to be relied upon. I ask with you, Sir, is it possible the proprietors of the *Times* are aware of what is being done in these matters with their great paper? Is it possible that, if aware of these facts, they could allow the infliction of damage to the prestige of the *Times*, which must surely outweigh by far the money gain derived from such an abuse of their advertising columns.

I am, Sir, yours truly, MEDICAL TEMPERANCE REFORMER.

January 29th, 1909.

THE LATE JOHN HOLDEN WEBB, M.R.C.S.Eng., L.R.C.P.LOND., OF MELBOURNE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-To no one more than myself has the news of the death of Mr. J. H. Webb caused more sincere regret and sorrow.

On many occasions I have drawn attention to his original work (a) with further views on the subject of cancer, received from him in correspondence, and published by me in accordance with his wish; and you, Sir, have been good enough, during the last four years, from time to time to publish these communications in some conjunction with my own.

In addition to the points in Webb's professional career noted in The Medical Press and Circular of January 27th, I think I am right in saying that formerly he was Assistant Surgeon in the Army Medical Department, and at the time of his death was Consulting Surgeon to the Melbourne Hospital. After settling in Melbourne, he rapidly acquired a reputation and enjoyed an extensive practice as a surgeon. With others, however, he suffered losses in the financial troubles in Australia some years ago.

During the last fifteen years he devoted himself to the subject of cancer, and though a surgeon himself, he was drawn to the clinical and medical side of the

In this respect, while recognising cancer as a local disease, in some cases due to causes having a purely local action and cured by operation, for the most part he regarded cancer as a general disease, due to central or intrinsic causes. Unable to define the boundary, in both forms he held that cancer is cell proliferation, due to the loss of some secretion, and in his opinion the crystallisation of cholesterin from the living cell, either locally from injury or de-pendent on some chemical change in the liver secretion, associated with deficiency of the bile salts or soaps, which normally hold cholesterin in solution.

Whether the theory was exactly right was a matter

of opinion, as he often wrote, but he was convinced himself of the influence for good in cases of inoperable cancer by his method of treatment by sodium oleate injections and purified ox gall by the mouth, and illustrated in various published cases, with independent confirmation. Even in regard to this treatment of his, he in no way asserted that he had reached finality. He thought it was on right lines, and capable of improvement.

I never met Webb, but his letters and his work appealed to me in their initiative and evident sincerity. Discouraged often by the lack of appreciation of his efforts and want of opportunity he experienced, there was nothing bitter in his letters, or petty about Webb. While holding to his views, he was willing to generously acknowledge the work of others or incorporate it with his own.

I was on the point of writing to assure him that

(a) The Lance', Oct. 12, 1901.

the subject of cholesterin in cancer, though still in a state of evolution at the present time, independently is receiving attention at home and abroad, and it is sad to think that Webb has not lived to find the recognition of his work which is his due. Pneumonia was the beginning of his illness, followed by heart and kidney complications. His death, at the age of 62, removes one whose name will be gratefully remembered by many who knew him and by those, like myself, who appreciated his work.

I am, Sir, yours truly,
J. A. SHAW-MACKENZIE.

Jan. 30th, 1909.

### **OBITUARY.**

WASHINGTON L. WINTERBOTHAM, M.B.LOND.,

J.P., V.D. WE regret to announce the death of Dr. W. L. Winterbotham, J.P., a gentleman who had been connected with Bridgwater for a large number of years. Dr. Winterbotham, who was about 70 years of age, had been in failing health for several years, but his death came about somewhat unexpectedly. He had been one of the leading medical practitioners in the town and neighbourhood, but since being joined by a partner several years ago, he had not actively pura partner several years ago, he had not actively pur-sued his profession. He was also well known, espe-cially years ago, as an ardent politician, and pos-sessing great powers of oratory, he ably championed the cause of Liberalism. At the time of his death he held the position of Chairman of the Bridgwater Divisional Liberal Association. He was one of the first county councillors of the borough, though he only held the position for one term of office, and he was also, some years ago, a member of the Town Council. He took great interest in the local hospital, of which he was Honorary Consulting Surgeon, and for many years had been a justice of the peace for the county. With the Somerset Archæological Society he had for years been closely identified, and that Society, by his death, has lost a most valuable member.

DR. GEORGE ELLIS.

THE death of one, who must have been the doyen of the medical profession in Ireland, occurred last week when Dr. George Ellis passed away in his hundredth year. Dr. Ellis, who lived at 91 Upper Leeson Street, had retired from active practice for some forty years, being a man of private means. He was a Fellow of the Royal College of Surgeons, and perhaps he had devoted himself more to the scientific than the active side of his profession. Dr. Ellis graduated at Trinity College in the year 1831, and received the degree of M.B. in 1834. In 1852 he published a work entitled "Irish Ethnology, Socially and Politically Considered." He was the vivor of three nonagenarian medical men, all of whom have now passed away. The two others were Sir John Banks, K.C.B., and Dr. Henry Tweedy.

### REVIEWS OF BOOKS.

AND CAMMIDGE ON THE PANCREAS. (a) MAYO ROBSON

This book shows careful study of the voluminous literature of the subject in every European language, the authors having taken great pains to collect informa-tion for the use of the English reader. Though full Though full of instruction for those willing to read a big work on the pancreas, the monograph might with advantage have been made less bulky by omitting a large number of debatable points and avoiding a like number of repetitions. The price at which it is published is

(a) "The Pancreas: Its Surgery and Pathology." By A. W. Mayo Robson, D.So.Leeds, F.R.C.S. Eng., and J. P. Cammidge, M.B.Lond., D.P.H.Camb, With numerous illustrations, London and Philadelphia: W. B. Saunders and Co. Price 21s. net.

somewhat prohibitive, seeing that it belongs to the class of books likely soon to be replaced by a new edition. The authors themselves candidly admit "that there are, as yet, many points on which observers are not agreed, and there are questions which still call for elucidation," and go on to say that "we do not consider that at present we are in a position to make more positive statements than those expressed in the chapter on chemical pathology, but we hope that we may shortly be able to do so." It being now recognised that the pancreas, instead of being a mere accessory organ of digestion, is greatly concerned in the maintenance of the health of the individual, clinicians will profit by a perusal of Messrs. Mayo Robson and Cammidge's elaborate work. Even the busy practitioner may well renew his knowledge of the anatomy, physiology, and pathology of the pancreas by glancing through the first 188 pages.

The chapter on chemical pathology may be reckoned as the main portion of the book, and proves laborious effort on the part of both authors. From their own observations on the fat contents of the fæces in disease of the pancreas they are able to confirm that in advanced pancreatic disease the stools have very typical characteristics-frequency, softness, bulk and whiteness, the last being due to the presence of neutral fats. In their opinion steatorrhœa is an unmistakable indication of pancreatitis, although, on page 327, they go on to state that in some cases of undoubted disease of the pancreas that came under their own personal observation the stools did not contain an excess of fats, and where an excess was present the relation between "neutral fats" and combined "fatty acids" was not markedly disturbed or there was excess of the latter contrary to what should be expected. The reasons they give for the absence of the excess of fat are:—

(1) Ingestion of food containing an abnormally small quantity of fatty material, owing to distaste for

(2) A diet containing fats which are readily digested and easily absorbed, e.g., a milk diet.

(3) Action of fat-splitting ferment in the stomach. The high proportion of combined fatty acids is accounted for by:-

 Bacterial action in the intestines.
 The examination being made in the early stages of the disease, before the pancreatic juice is diminished, or when actually increased.

(3) Enteritis hurrying the contents of the intestines onwards to the large bowel before being absorbed.

In spite of a good deal of original observation, and their "improved method" of examination of urine, they do not consider the presence of a pentose in that excretion as being dependent upon disease of the pancreas. They maintain that a positive reaction by the improved method of performing the so-called "pancreatic reaction" is suggestive of inflammatory disease of the pancreas, but they are not prepared to contend that it is pathognomonic of pancreatitis. We agree in their advice that in every suspected case of disease involving the pancreas the stools and urine should be subjected to examination by an experienced clinical pathologist, as his interpretation may, in the majority of cases, help to "clinch the diagnosis." The authors have taken great trouble to emphasise the importance of taking into account the examination of the urine and fæces, as well as clinical symptoms, before diagnosing disease connected with the pancreas. The referto cases in which pancreatic disease has been mistaken for sprue and malaria are interesting. pancreatic origin of diabetes is well sketched in the chapter devoted to it, and, in spite of the conflicting views held by the profession, both at home and abroad, the authors furnish instructive reading on the subject. They hold that glycosuria is not common in pencreatic disease, and when sugar is found in the urine it generally occurs in the form of dextrose—maltose rarely—pentosuria being very exceptional. The authors' classification of inflammatory diseases of the pancreas is the generally accepted one, though perhaps without the sub-division, under acute, in group B. We differ from them when they speak of ultra-acute, but that is only a matter of opinion. Thirty-four pages are devoted to general symptomatology and diagnosis; a good deal of what had been said of fæces and urine is repeated here. This portion of the book is a careful survey of the symptoms and physical signs met with in the disease, and may be commended to the attention of those who so firmly hold the idea that disease of the pancreas is unrecognisable during life. The histories of cases given in this chapter, and in the remainder of the work, are worthy of careful perusal. The diagrams are deserving of praise, especially those reproduced from Testut.

TREATMENT OF INTERNAL DISEASES. (a)
HERE we have a portly volume of upwards of 600
pages exclusively devoted to treatment—it positively
makes the pulse beat more quickly in joyful anticipation of a therapeutical feast. The pages teem with
prescriptions, couched in approved dog-Latin; we are
not even left in doubt as to terminations—often a
bugbear to the prescriber.

Three hands, or rather heads, have contributed to the English, or, shall we say, American version of the gospel of therapeutics. Dr. Ortner has his say, then the translator renders it into English, whereupon the Editor trips in between brackets, in a nagging sort of way, and handles the author's statements quite unceremoniously, often, indeed, flatly contradicting them. The effect on the reader is a trifle disconcerting, because he cannot help sympathising with the author, who is not there to defend himself. It is only fair to add, however, that Dr. Potter's interjections are characterised by sound common-sense, and his modifications and suggestions will probably commend themselves for Were it not for some of his additions, adoption. indeed, the volume would in many respects not be up-to-date." Merely to take the treatment of hæmoptysis, by way of example, the author prescribes ergot, hamamelis, and the whole series of reputed astringents in the old-fashioned way, apparently in blissful ignorance of the fact that, though still prescribed, they are hopelessly discredited. Fortunately, Dr. Potter is there to recall the fact, however discreetly, that remedies which lower the blood pressure are vastly more effectual in arresting hæmorrhage than those that tend to raise it. The same remark applies to the hypodermic exhibition of quinine in severe cases of malaria, for which we are indebted to the Editor.

There are many good features about the book, redolent of the pharmacy though it be. The author is particularly good on diet and regimen, and his instructions are characterised by detail and thoroughness, and for this reason cannot fail to be appreciated by the practitioner who is sick of vague general directions and sighs for something concrete, lists of articles of food and their quantities, schemes for the day's meals, and the various ways of preparing the appropriate substances.

It strikes us as somewhat remarkable that it should have been thought necessary to adapt a German book on therapeutics as though the task of compilation—for that is all it amounts to—could not have been done as efficiently by an Anglo-Saxon author off his own bat. By whomsoever written, it constitutes a very handy and resourceful work of reference, from which every practitioner may derive useful practical information.

### CLIMATE IN RELATION TO MAN. (b)

A WORK on climate ought to possess considerable interest for the general reader, inasmuch as climate is in reality an aggregate term for weather, and weather is a never-failing topic of conversation. We fear, however, that even in a work "which can be read by an intelligent person who has not had special or extended training in the technicalities of the science," as this one professes to be, the science will only appeal to those who have technical reasons for consulting its

pages. The earlier chapters are devoted to a classification of climates and a description of the zones within which each kind of climate is met with. Here we learn what constitutes a temperate climate (which may roughly be described as eminently changeable and uncertain), and we are taught the peculiarities of the extreme climates. The next step is to explain, as far as may be, how these climatic conditions are brought about.

To medical readers the chief interest of this compilation will be found in the chapter on the "hygiene of the zones." In it we have general considerations on the relations of climate and health which, as the author aptly remarks, is a very complex subject for the study of the causal connection between atmospheric conditions and disease, and has led observers to very contradictory conclusions. No doubt much of the confusion is due to the pernicious practice of generalising on insufficient data. Then, too, there are so many circumstances and conditions, independent of climate, that influence the incidence of disease, so that only the widest, not to say vaguest, conclusions are permissible.

The death-rates that obtain in this or that zone afford but a partial and imperfect idea of the morbidity of such zones, yet these rates constitute practically the only certain statistical data available.

Incidentally, we learn something concerning diseases peculiar to certain climates, their mode of propagation and the means of avoiding them, and this information will, doubtless, appeal more to non-medical readers anxious to cultivate the "intelligent adaptation of the physiology of the individual" which makes for acclimatisation.

The book contains much interesting information on habits of life under various climatic conditions and on the adaptability of the human organism to extremes.

### AN ALABAMA STUDENT. (a)

This volume of biographical essays is a collection of addresses already published in various medical The opening essay from which the book journals. derives its title deals with the life story of a certain Dr. John Bassett, who lived in the first half of last century. This man, devoted to medical science, left his native shores and visited France, and also this country in pursuit of learning. The extracts from his letters which Professor Osler gives are of great interest. They tell of a man of originality of mind and purpose, not one of the common herd, content to go on in the same hum-drum mode of existence as his fellows. He died in 1851 of tuberculosis. In a letter written to a friend in the spring of that year, he says: "This world has never occupied a very large share of my attention or love. I have asked but little of it, and got but little of what I asked." What was true of Bassett, is true of many medical martyrs of our own time. Many a worker is doomed to remain unknown to fame because of jealousies and misunderstandings, alas! too common in the medical profession. Many a man if he had his due would to-day be at the top, while some who, from private wealth or other causes, would be destined to take a back seat, so to speak, in the world of medicine. Some of the other notable characters considered are Thomas Dover, John Keats, Oliver Wendell Holmes, John Locke, William Pepper, and Sir Thomas Browne. The concluding essay is on Harvey, being the Harveian Oration delivered before the London College of Physicians in 1906. The lives of great men in our profession must ever stimulate us to fresh endeavours to follow in their footsteps. Centuries may have come and gone since they lived and worked, but medicine is medicine still. Our patients are the same frail creatures of a day; and if we can but catch the spirit and somewhat of the influence left by the great ones whose names are here recorded, we shall, indeed, owe a debt of gratitude to Professor Osler for issuing these essays in this handy form.

<sup>(</sup>a) "Treatment of Internal Diseases." By Dr. Norbert Ortner, of the University of Vienna. Edited by N. B. Potter, M.D., Physician to the New York City Hospital. Translated by F. H. Bartlett, M.D. (from the Fourth German Edition). Philadelphia and London: J. B. Lippincott Co.

B. Lippincott Co.

(b) "Climate considered especially in Relation to Man." By Robert de Courcy Ward, Assistant Professor of Climatology in Harvard University. London: John Murray. 1908.

<sup>(</sup>a) "An Alabama Student, and other Biographical Essays." By William Celer, M.D., F.R.S., Regius Professor of Medicine, Oxford; Honorary Professor of Medicine, Johns Hopkins University, Baltimore. Oxford: Clarendon Press. 1908. Price 7s. 6d, net.

### NEW BOOKS AND NEW EDITIONS.

NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publication of our last monthly list:—ADLAID AND SON (London).

Medical Reports of the Central London Throat and Ear FILL ALGAI (Paris).

Neurasthenio et Neuroses leur Guerison Definitive en cure libre. Dr. Paul-Emile Levy. Pp. 407. Price 4 francs.

EDWARD ARKOLD (London).

The Paul-Emile Levy. Pp. 407. Price 4 francs.

EDWARD ARKOLD (London).

REPLIE ALGAI (Paris).

Neurasthenio et Neuroses leur Guerison Definitive en cure libre. Dr. Paul-Emile Levy. Pp. 407. Price 4 francs.

EDWARD ARKOLD (London).

Alds to Obstetrice. By Alex. Hill, M.A., M.D., F.R.C.S.

BILLIERE, TINDALL AND GOX (London).

Alds to Obstetrice. By Banuel Nall, B.A., M.B.Cantab.,

M.R.C.P.Lond. Revised by C. J. Nopean Longradge. M.D.

184. P. 195. ed. Dr. 185. Price 28. ed. Dr. 185. Price cloth, 25. ed. net.

Diathesis and Ocular Diseases. By A. Maitland Ramsay, M.D.

Illustrated. Pp. 184. Price 28. ed. threnat. Nose, and Ear.

Parctical Guide to the Diseases of the Throat. Nose, and Ear.

Parctical Guide to the Diseases. By A. Maitland Ramsay, M.D.

Hinter C. 195. Price 28. ed. threnat. Nose, and Ear.

Catechism of Hematology. By Robert Lincoln Watkins, M.D.

Pp. 32. Price 38. ed. net.

Catechism of Hematology. By Robert Lincoln Watkins, M.D.

Pp. 32. Price 38. ed. net.

Sons JANY B. A. S. Pp. 123. Price 68. net.

Hinte to Ships' Surgeons. By J. F. Elliott, L.R.C.S., L.R.C.P.

The Rat Problem. By W. R. Boelter. Illustrated. Pp. 165.

Hinte to Ships' Surgeons. By J. F. Elliott, L.R.C.S., L.R.C.P.

The Rat Problem. By W. R. Boelter. Illustrated. Pp. 165.

Pp. 40. Price 28. net.

The Edinburgh Steroscopic Atlas of Obstetrics. Edited by G. F. Barbour Simpson, M.D., etc., etc., and Edward Burnet, B.A., M.B., etc., etc., with preface by Prof. Sir

Category of Parchament Co. (London).

The Edinburgh Steroscopic Atlas of Obstetrics. Edited by John Lane. 1909. Pp. 32. Price 18. ed.

Churca And Son, Lantaren, Ph. 186. Price 18. ed. net.

Harray J. Glaisers (London).

The

JOHN WRIGHT AND SONS, LTD. (Bristol).

An Index of Treatment. By various writers. Edited by Robert Hutchison, M.D., L.R.C.P., and H. Stansfield Collier, F.R.C.S. Fourth Edition. Pp. 926. Price 21s. net.

#### News in Brief. MEDICAL

#### Research Defence Association—Dublin B anch.

A MEETING organised for the purpose of forming a Dublin Branch of the Research Defence Society was held last week in the Theatre of the Royal Dublin Society, Leinster House. Sir John G. Nutting, Bart., D.L., presided. The meeting was very numerously attended.

The Chairman, in opening the proceedings, said that he took the chair in the unavoidable absence of the Earl of Cromer. The fact that in Dublin, before the branch had actually been formed, 200 persons of every class and profession, in addition to the medical men, had announced their intention of joining the proposed branch, showed that there was a widespread feeling in Ireland in favour of scientific research. The formation of the proposed branch was undertaken for the purpose of dispelling misapprehensions on the subject.

The Very Rev. the Dean of St. Patrick's proposed:—

"That a Dublin Branch of the Research Defence Society be, and is hereby, established." In doing so, Dean Bernard said that he felt honoured by the confidence which had entrusted him with proposing that resolution. But, at the same time, he had to confess that it was a humiliating circumstance that it should be necessary to establish a branch of the Society in Dublin. It was humiliating to think that the advocates of science should be so hampered in their efforts, and so slandered as to their motives, that a Society of that sort should be needed amongst those who benefited by their labours in the cause of humanity. He regarded the Defence Research Society exactly as he regarded the Society for the Prevention of Cruelty to Children. It was established in the name of humanity, for the sake of suffering mankind, and it was as truly humanitarian as the Society for the Prevention of Cruelty to Children.

Count Plunkett, in seconding the motion, said that it was not proposed to ask for liberty to inflict purposeless pain, nor did they want to defend any wanton action.

The motion, on being put to the meeting, was carried, with two dissentient votes, on a show of

Mr. Stephen Paget, F.R.C.S., Hon. Secretary of the Society, read a letter which he had received from its President, the Earl of Cromer, in which he regretted that he was unable to attend, and eulogised the manner in which Sir Henry Swanzy had worked.

Mr. Paget said he had to convey the congratulations and thanks of the London Committee, and, so far as he could, of the members of the Research Defence Society, to those taking part in the inaugural meeting of the Dublin branch. It was just a year ago that day that the Society drew its first breath. There were seven of them, and they sat round a table that had belonged to Sir James Paget. Referring to the work of the Committee in London, Mr. Paget said the Society had sent their literature and speakers to a great number of debates, but they drew the line at accepting direct challenges from anti-vivisection societies, or arranging with them the terms of a debate, preferring to do their work in their own way. The work of publication was a very important one, but more important than any amount of publishing was the creation of branches up and down the country. During the past year branches had been, or were just being, formed in many important centres, including

Cambridge, Chester, Bournemouth, Oxford, Leeds, Liverpool, Manchester, York, Hull, and Dublin.

Dr. Horne, President of the Royal College of Physicians, moved:—"That the sincere thanks of the Dublin Branch of the Research Defence Society are hereby given to the Right Hon. the Earl of Cromer, President of the Society, for his kind message, conveyed to Mr. Stephen Paget." He congratulated the Society upon having such a man as Lord Cromer for

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their President. Referring to experiments on arimals in Ireland, Dr. Horne said the total number of people who were permitted by the laws to experiment was 14, and out of that 14 there were four last year who performed no experiments whatsoever. The total number of experiments performed was 158, and the animals that were used were mice, guinea pigs, rabbits, dogs, goats, and a cat. Mice were the chief objects for making these experiments with. Only three dogs and two goats were experimented u; on. As Mr. Paget had explained, a large number of these experiments were simply innoculations, and that was why mice and guinea pigs and rabbits were the chief animals to be experimented upon. The resolution was carried.

On the motion of the Rev. Thomas A. Finlay, S.J., seconded by Mr. Alexander Blood, K.C., a Committee was formed to work the Dublin Branch of the Society for the ensuing year. The following is the list of the Committee:—Dr. Coleman, C.M.G., Mrs. Frances Dixon, Dr. Frank Dunne, Mr. J. Magee Finny, President of the Royal Academy of Medicine, Mr. Joseph Geoghegan, Dr. Andrew Horne, President of the Royal College of Physicians, Mr. John Lentaigne, President of the Royal College of Faysilians, Mr. John Lentaigne, President of the Royal College of Surgeons, Dr. Lumsden, Professor Mettam, Miss Isabella Mulvany, LL.D., Professor Edmond J. McWeeeney, Count Plunkett, Mr. George Prescott, Dr. Scharff, Mr. L. Edward Steele, Sir Henry R. Swanzy, Professor W. H. Thompson.

University College, Cork.

A MEETING of "Old Corkonians" was held at 20 A MEETING of "Old Corkonians" was held at ao Hanover Square last week, under the Presidency of Sir Thomas Gallwey, M.D., K.C.M.G., to protest against the changing of the name of Queen's Collge, Cork, to the University College, Cork, Dr. Macnaughton-Jones proposed the following resolution: "That this meeting of Old Corkonians has heard with regret of the change in the name of their Alma Mater. Alma Mater. They desire to put on record their indignation at an act which was as uncalled for as it was unjustifiable." He pointed out that if they turned to other new Universities they would find that when Owens College, Yorkshire College, and University College, Liverpool, became part of the new Manchester and Liverpool Universities, they re-

new Manchester and Liverpool Universities, they retained their names. The resolution was seconded by Mr. A. Johnston, LL.B., and carried unanimously. Dr. Charles Haines then proposed: "That this resolution be forwarded to the Right Hon. the Prime Minister, his Excellency the Lord Lieutenant, the Chief Secretary to the Lord Lieutenant in Ireland, the Right Hon. Arthur Balfour, M.P., the President of Queen's College, Cork, and the principal organs of the Press in Ireland." This was seconded and carried unanimously. The proceedings then terminated.

### PASS LISTS.

### Royal College of Physicians, London.

AT a meeting of the Comitia of the College on Thursday last, the L.R.C.P.Lond. was conferred upon eighty-one candidates who have completed the final examination in Medicine, Surgery, and Mid-wifery of the Conjoint Board, and have complied with the ecessary by-laws.

The Diploma in Public Health was conferred upon the following candidates conjointly with the Royal

College of Surgeons at the same meeting:

Alfred Ball, M.B., B.S.Lond., L.R.C.P., M.R.C.S., Alfred Ball, M.B., B.S.Lond., L.R.C.P., M.R.C.S., University College Hospital; Robert James Bethune, M.D., B.Ch., R.U.I., Queen's College, Belfast, and University College Hospital; Arthur Burnell Carter, L.R.C.P., M.R.C.S., Cambridge University and Guy's Hospital; Bertram Walter Cherrett, M.B., B.S.Lond., L.R.C.P., M.R.C.S., St. Bartholomew's Hospital; James Clark, M.D., Ch.B. Aberdeen, M.R.C.P.Lond., Aberdeen University and University College Hospital; James Alfred Patrick Cullen, M.B.Lond., L.R.C.P., M.R.C.S., London Hospital; Leonard Fabian Hirst, M.B., B.S.Lond., L.R.C.P., M.R.C.S., University College Hospital; Duncan Matheson Johnston, L.R.C.P., M.R.C.S., Durham University and St. Bartholomew's Hospital; Andrew Alexander McWhan, M.B., Ch.B.Glas., Glasgow I nisity and University College Hospital; Freuerick Septimus Penny, Captain R.A.M.C., M.B.I ond., L.R.C.P., M.R.C.S., King's College and Royal Army Medical College; Norman Hamilton Walker, M.B., B.S.Lond., L.R.C.P., M.R.C.S., St. Bartholomew's Hospital; Arthur Harold Wilson, L.R.C.P. and S.Edin., L.F.P. and S.Glasg., Birmingham University; Subrahmanyam Yenamandram, L.M. and S. Madras, Madras and King's College.

### Royal Colleges of Physicians and Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations of the above Board, held in Edinburgh, were completed on January 23rd, with the following results:—

Passed the First Examination.—Hargobind Lal Batra, Kul Bhushan, Edwin W. Marsh, Anthony F. Henriques, Padam A Dastoor, Baboorao G. Shiroadkar, Arthur I. Luke, Maganlal M. Daru, Jugal K. Sharma, Dinshaw B. Gazdar, Erach D. Shroff, Nariman Sharma, Dinshaw B. Gazdar, Erach D. Shroff, Nariman B. Mehta, Kedar Nath, Norman S. Williams, Seringapatam N. S. Aiyangar, Thiruchelvam Sabastian, William Elder, John Hegarty, Hubert W. Ward, Victor T. W. Eagles, Fakir Chand, William A. Reardon, William A. Rees, Hugh W. McH. Wallace, Cyril M. Willmott, Emmanuel P. Ghose, John W. Craig, Furdon F. Keravalla, William P. Over, Prabodh C. Banerjee, and Arthur S. Douglas; and 3 passed in Fhysics, 3 in Biology, and 1 in Chemistry.

Passed the Second Examination.—Eustace Thorp, Tom E. Ferguson, John M. Chrystie, John M. Dalzell.

Tom E. Ferguson, John M. Chrystie, John M. Dalzell, Francis W. Grant, William J. H. Davies, Zebina Annette De Cruz, Edward C. Hamilton, David A. Evans, Narmadashanker P. Vaid, and John Adami; and 2 passed in Anatomy and 5 in Physiology.

Passed the Third Examination.—Bickford J. Hattam, Howard V. A. Gatchell, William Whitfield, William T. Henderson, Hargobind L. Batra, Ernest W. Wilbourne, George B. Moon, Emma M. Johnstone, Daniel Hickey, Kul Bhushan, Edwin W. Marsh, Anthony F. Henriques, and Arthur I. Luke; and 2 passed in Pathology

riques, and Arthur I. Luke; and 2 passed in Pathology and 3 in Materia Medica.

The following passed the Final Examination, and were admitted L.R.C.P.E., L.R.C.S.F., and L.F.P. and S.G.:—Hormusji Jehangir Dadyseth, Bombay; Franklin Joseph de Souza, India; William Forest Mitchell, Derbyshire; Thomas Mitchell Jamieson, Co. Tyrone; Aldington George Curphey, Jamaica; James Bolton Kelso, Co. Derry; William Frederick Buist, Argentine; George Noel Braham, Bath; Kathleen Reed, Calcutta; Hilda Lucy Keane, Bombay; Timothy John Vaughan, Co. Cork; George FitzWilliam Forde, Cork; Harold Ainscough Higginson, Bolton; Henry William Turner, Glasgow; Alexander O'Flaherty, William Turner, Glasgow; Alexander O'Flaherty, Galway; Bhaskar Mahadev Tembe, India; Ernest Gibson, Cork; Edward Corry Wilford, Canada; John Elliott Brown, Jamaica; Abdul Majid Shah, India; Ganesh Vishnu Bhatavadekar, Poona; Hari Ram-Ganesh Vishnu Bhatavadekar, Poona; Hari Ramkrishna Gogte, Bombay; Archibald Davidson, Melbourne; Kaikhusru Sorabshah Commissariatwalla, Bombay; Thomas Brownlie McKendrick, Wishaw; Frank Humphrey Kiddle, India; Dinkar Sakharam Sardesai, Bombay; Peter Stewart, Upnall; Harry Simpson Harling, Castleford; James Aiken, Edinburgh, and Edward John Lumsden, Ireland; and 15 passed in Medicine and Therapeutics, 15 in Surgery and Surgical Anatomy, 30 in Midwifery, and 24 in Medical Jurisprudence.

### Centeint Examinations in Ireland.

THE following candidates have passed the Second Professional Examination of the Royal College of Physicians and the Royal College of Surgeons, Jan., 1900;—T. F. O'Donnell (with honours); J. H. Barry, P. W. Black, P. Daly, J. M. Gilmor, C. J. Halpin, A. Hamilton, C. W. Joynt, C. J. Lanahan, A. G. MacIlwaine, D. McDevett, A. J. Neilan, P. J. O'Connell, D. P. H. Pearson, F. Phelan, C. Roche, P. R. Todd, A. Wiley, F. Webster.

### NOTICES TO CORRESPONDENTS. &c.

Correspondence requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Institut, and to avoid the practice of signing themselves "Reader," "Subsoriber," "Old Subsoriber," etc. Much confusion will be spared by attention to this rule. SUBSCRIPTIONS.

SUBSCRIPTIONS.

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Suppage.—The first woman medical practitioner was Mrs.
Elisabeth Blackwell, who was registered in 1859. Dr. Klisabeth
Blackwell has retired from practice many years. She lives at
Hastings, and is 87 years old. She was born near Bristol, but her
father emigrated to the United States when she was 11 years old.
She decided to become a doctor, and, after a struggle, was accepted
as a student at Geneva College, New York. In 1849 she received
the degree of M.D. from that university, and then studied in
Europe. She practised in America, and there established the
New York Infirmary for Women and Children. In 1858 she
returned to England, wrote "The Laws of Life in Reference to
the Education of Girls," and commenced her friendship with
Mrs. Garrett Anderson.

J. P. Sandlands.—With regard to your further letter, we can
only state that there are limits to our space and to the degree.

J. P. Sandlands.—With regard to your further letter, we can only state that there are limits to our space and to the degree of buffoonery we can permit in our columns.

EXPERIMENTS ON PATIENTS.

### To the Editor of THE MEDICAL PRESS AND CHROULAR.

To the Editor of THE MEDICAL PRESS AND CHROCLAR.

SIR,—Mr. Robbins has altogether run away from the point of argument, and initiated a discussion on his own account, involving issues which concern lawyers more than doctors.

He will observe that I was not discussing the advisability from a legal point of view of a boarding-house proprietor advertising "No thieves here," but started with the comparison between that announcement and the "No experiments on patients." I held, and still hold, that in both cases the public would infer some special immunity from theft and experiments not guaranteed by hospitals and boarding-houses in general, and hence "analogous" cases.

I am, Sir, yours truly,

I am, Sir, yours truly, CLEMENT H. SERS.

Brighton, January 29th, 1909. This letter must close the correspondence.-ED.

• This letter must close the correspondence.—ED.

N. K. (Marble Arch).—The address of the National Truss Society
is 2 Arthur Street West, London, S.E. The Society was founded
in 1786 originally for the relief of the ruptured poor, but its
field of usefulness has been extended to the provision of a large
variety of surgical appliances, such as elastic stockings, kneecaps, catheters, and so on. A subscriber's letter, we regret to
note, has to be obtained by the applicant, who, on presenting
the same, is entitled to skilled advice and the git of an
instrument. There is also the City of London Truss Society,
under the patronage of the King, for the supply of trusses only.
The address is 35 Finsbury Square, London, E.C.
F.R.C.S. (South Molton).—It is an interesting fact that septic
misohief often follows the accidental prick of a thorn, although
it is not easy to see how specific pathogenic microbes should
find a foothold on a thorn outdoors in the country. In some
cases, of course, the infection is secondary. We know of one
case in which a gardener died of acute septio infection two
days after pricking his finger with a rose thorn.

### Meetings of the Socielies, Tectures, &c.

WEDNESDAY, 3RD FEBRUARY.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

THURSDAY, 4TH FEBRUARY.

THURSDAY, 4TH FEBRUARY.

NORTH-EAST LONDON CLINICAL SOCIETY (Prince of Wales's Hospital, Tottenham, N.).—4.15 p.m.: Clinical Cases.

RONTGEN SOCIETY (20. Hanover Square, W.).—8.15 p.m.:
Discussion on the Transport of Ions (opened by Dr. H. Pirie).
NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's teneral Hospital, Tottenham, N.).—2.30 p.m.: Gynscological Operations (Dr. A. E. Glies). Clinics: Medical Out-patient (Dr. A. J. Whiting); urgical (Mr. H. W. Carson); X-Rays.
3 p.m.: Medical In-patient (Dr. G. P. Chappel).
St. John's Hospital. For Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture: Syphilis: Papular (I.). Miliary; II., Lenticular; III., Squamous; IV., Moist); Pustular, and Tuberculous.

FRIDAY, 5TH FEBRUARY.

FRIDAT, 5TH FERBUARY.

ROTAL SOCIETY OF MEDICINE (LARINGOLOGICAL SECTION) (20, Hanover Square, W.).—5 p.m.: Cases, Specimens, etc.: Will be shown by Dr. Dundas Grant, Sir Felix Semon (with demonstration on epidiascope), Dr. Milligan, Dr. Knowles Renshaw, Dr. Watson Williams, Mr. Clayton Fox, Mr. Chichele Nourse, Dr. Jobson Horne, Mr. Harold Barwell, and others.

ROTAL SOCIETY OF MEDICINE (SECTION OF ANXESTRETICS) (20, Hanover Square, W.).—8.30 p.m.: Meeting: To Consider the Advisability of Legislation to Control the Administration of Anxesthetics.

Advisability Anæsthetics.

Anæsthetics.
West London Medico-Chirurgical Society (West London Hospital, Hammersmith Road, W.).—8 p.m.: Pathological Evening. Specimens shown at 8 p.m.
NORTH-EAST LONDON POST GRADUATE COLLEGE (Prince of Weles's General Hospital, Tottenham, N.).—10 s.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.50 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

Saturdat. 6th February.

R. M. Leslie).

SATUBDAY, OTH FEBRUARY.

ROYAL SOCIETY OF MEDICINE (OTOLOGICAL SECTION) (20. Hanover Square, W.).—10 a.m.: Dr. McBride: Dermoid of Mastoid Region. Dr. Dan McKenzie: Notes on the Position of the Patient after Operations on the Mastoid Dr. Kelson: Notes on a Case of White Membranous Deposit in the Auditory Meatus of a Girl. Mr. Hunter Tod and others will show Cases.

### Appointments.

CHEESMAN, EDWARD ROBERT RAMSAY, L.S.A.Lond., Public Vaccinator by the Shafteelury (Dorset) Board of Guardians. COWELL, E. M., M.B., B.S., House Surgeon to University College Hospital.

DANKLS, D. W., M.B., B.S. Long., M.R.C.S. Eng., Casualty House Surgeon at St. Mary's Hospital, Paddington, W.

ELHOTT, T. R., M.D.Cantab., House Physician to University College Hospital.

HERD, HERRY, M.B., Ch.B.Edin., Assistant School Medical Officer to the Manchester Education Committee.

LONGTON, GEORGE HAROLD, M.R.C.S., L.R.C.P.Lond., Honorary Ansesthetist to the Royal Hospital for Diseases of the Chest. MCNAUGHTON, J. G., M.D.Edin., M.R.C.P.Edin., Honorary Assistant Physician to the Manchester Hospital for Consumption and Diseases of the Throat.

RYOATE, DAVID JOHN, L.R.C.P.Lond., M.R.C.S., L.S.A., District Medical Officer by the Williton (Somerset) Board of Guardians. Scott, S. Gilbert, M.R.C.S., L.R.C.P.Lond., Radiographer to the Hospital for Accidents, E., and Honorary Radiographer to the Hospital for Diseases of the Heat, Soho Square.

YONGE, EUGENE S., M.D.Edin., Honorary Physician to the Manchester Hospital for Consumption and Diseases of the Throat.

### Bacancies.

Durham County Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, laundry, and sttendance. Applications to the Medical Superintendent, Durham County Asylum, Winterton, Ferryhill.

Northampton General Hospital.—Senior Resident Medical Officer. Salary, £120 a year, with apartments, board, washing, and attendance. Applications to C. 8 Risbee, Secretary, Superintendent.

Roxburgh District Asylum, Melrose.—Assistant Medical Officer. Salary, £150 per annum, with board, rooms, and washing. Applications to the Medical Superintendent.

County Asylum, Mickleover, Derby.—Junior Assistant Medical Officer. Salary, £120 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

board, washing, and attendance. Applications to the Medical Superintendent.

Cambridgeshire, etc., Asylum.—Senior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing in the Asylum Applicatous to T. Musgrave Francis, Clerk to the Visitors, 18, Emmanuel Street, Cambridge.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary, £250 per annum, with board, furnished apartments, and attendance. Applications to the Medical Director at the Asylum.

Northumberland County Asylum, Morpeth.—Junior Assistant Medical Officer. Salary, £120 per annum, with board, apartments, laundry, and attendance. Applications to the Medical Superintendent.

### Marriages.

MORGAN—COWTAN.—On Jan. 28th, at St. George's, Campden Hill,
Conwy Ll. Morgan, M.D.Lond., of The Firs, Droitwich,
younger son of Conwy Lloyd Morgan, F.R.S., LL.D., Principal
of Bristol University College, to Mary, younger daughter of
Frank Cowtan, of 4, Aubrey Road, Kensington.

### Beaths.

MACKAY.—On Jan. 29th. at Lansdowne House. Devizes, the residence of H. J. Mackay, M.D., her step-son, Alice Louisa Mackay, aged 81
READ.—On Jan. 28th. at 11, Petersham Terrace, London. Thomas Lawrence Read, M.R.C.S., aged 76
RUGO.—On Jan. 30th, at Westgate, Ohiohester, Mary Frances Hopestill Rugg, widow of Richard Rugg, Esq., late of Brighton, F.R.C.S.Eng., aged 91.

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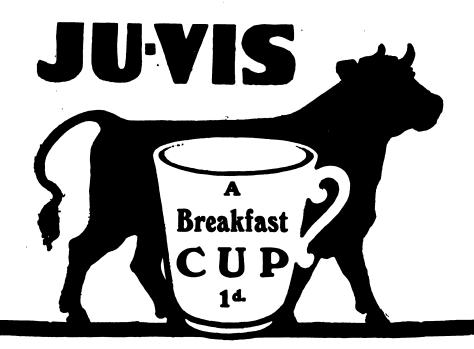
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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, FEBRUARY 10, 1909.

No. 6.

### Notes and Comments.

SOME of the South Shields councillors The South resent the action of the British Shields School Medical Association for suggesting Medical Officer. certain conditions of appointment of

the new school medical officer. One particular point raised a heated discussion the other day, namely, the clause forbidding that official from beginning practice in South Shields within three years of the termination of his appointment. In proposing the rejection of this proposal, a member remarked it had been inserted in the interest neither of the committee nor of the children, and it was no duty of the committee to protect the medical profession. "It was suggested," he continued, "that the medical officer might attempt to insinuate himself into the favour of the parents whose children had been under his attention in school, but he thought he was more likely to increase the practice of other local medical men by discovering physical defects in the children and recommending the parents to obtain medical advice." The seconder of the amendment thought "doctors ought to be allowed to fight their own battles," while one of his supporters described the action of the British Medical Association as trades unionism of a very low level. The amendment was lost by the narrow margin of seven votes to six. So in future the South Shields medical officer may dismiss any idea of settling in that district upon giving up his school appointment.

The Value of School Straws show which way the tide is flowing, and the South Shields councillors reflect with tolerable Appointments. accuracy the attitude of the average

man when the medical profession makes any stand for the protection of its "right to What would these scarcastic councillors say if a sub-committee recommended that engineers, schoolmasters, lawyers, surveyors, and so on, should be brought into their town to hold official posts, with full liberty to compete at any time with citizens already established in the same pursuits? We can imagine the sort of outcry the lawyers would make if a solicitor were thus imported. As to the taunt of trades unionism, we fail to see its relevance. The justice of the principle of collective defence was long ago conceded by the public and endorsed by the legislature. Why, then, should it be derogatory for the profession to follow, albeit longo intervallo, in the footsteps of the lawyers, and attempt to protect its members against certain obviously unfair forms of competition? Another aspect of the matter suggested by the South Shields discussion is the value, or otherwise, of these school posts to medical men. The salary, although enough for a young man, is rarely or never on a scale sufficient for the increasing wants of mature

age, when most men have a wife and family to support. There is small chance of saving money out of the income. The officer is apt to find himself unfit, more or less, for general practice, and has to live for an inadequate present. From many points of view, we should recommend any medical man to weigh the pros and cons of the situation carefully before applying for any post which excludes him from other work.

THE Court of Appeal last Friday The Court of confirmed the decision of Mr. Justice Appeal Channell with regard to the case in on Accidents. which a gentleman who died of pneumonia was held to have died of an accident, within the terms of a policy issued by the Lancashire and Yorkshire Accident Insurance Company. The facts may be briefly recalled. Mr. Etherington, whose executors were plaintiffs in the original case, went hunting after having just recovered from an attack of influenza, and, sustaining a fall on wet ground, but no trauma, promptly became ill. Next day, against medical advice and though he was feeling great pain, Mr. Etherington travelled to London and worked till 6 p.m., when the physical signs of pneumonia developed. Of this disease he died six days later. Now, the policy laid it down that the accident must be the direct or proximate cause of death, and not "when the direct or proximate cause was disease or other intervening cause," although such other cause may have been aggravated by such accident. Lord Justice Farwell, among his remarks, said that it was plain to his mind, on the construction of the primary liability, that the deceased gentleman died from the direct effect of the fall.

Also on Disease.

It is a curious state of affairs which endows His Majesty's judges with a knowledge of pathology in advance of that possessed by physicians. In this case, for instance, we think

that had the policy been one covering influenza and its consequences, but no accident, it might properly have been claimed that the pneumonia was one of those consequences. So that we would have the curious result that the death was due to the accident or the disease, according to how it suited the policy-holder to claim. No event in life is due to one single cause, but to a combination of many causes, and in regarding a death as due to accident, the usual interpretation is that the accident is the effective cause, to the reasonable exclusion of others. It is hardly using words in their proper way to say, for example, that a man in the last stages of cancer died of an "accident" because his nurse dropped a bed-pan on him and he fell dead of syncope. In Mr. Etherington's case it is quite

likely he would have died of post-influenzal pneumonia if he had never left his bedroom, and even more so if he had an ordinary day's hunting without any accident. Moreover, if he had not travelled the next day he might not have died. We confess we have not much sympathy with accident policies which exclude disease, but if people desire and companies issue them, we fancy they ought to be interpreted on some recognised principle, and if the old distinctions between disease and accident are to go by the board, some other rule other than "heads I win, tails you lose" ought to be invented.

At a recent meeting of the Central Departmental Midwives Board a resolution was Committee on passed urging the Lord President of Midwives. the Council to add to the Depart-

mental Committee considering the Midwives Act representatives of general medical practitioners and midwives, as the Board considered that such additions would greatly enhance the value of the report eventually to be made by the Committee. It is not a little paradoxical that a committee should be appointed without such interests being represented, considering that it is they which are almost entirely affected, but when we consider that the State studiously ignores the medical interest in all things pertaining to State medicine, it is not, perhaps, so surprising as first appears. It is troublesome, no doubt, to obtain representatives of a comparatively unorganised body like the midwives, especially considering the com-paratively humble level of education that exists among them, but the difficulty is not insuperable, whereas, in the case of medical men, a good representative general practitioner could be chosen at once from amongst the three gentlemen who are delegated by their brethren to look after their interests on the General Medical Council. The new Lord President might do something to show that he is not a figure-head by promptly remedying this anomalous position.

Dark or Fair?

"BLUE-BLOOD" has long passed into ordinary parlance as a synonym for aristocracy. The expression, of course, is derived from the Spanish,

whose Northern conquerors, and, consequently, whose ruling caste, were fair. The fair, whose blue veins showed through the skin, were the descendants of Visigoths, and therefore masters of the dark aborigines. To this day the flaxen-haired, fresh-complexioned English girl remains the highest type of beauty to Spanish eyes. But the tawny-haired, tawny-bearded giants who came out of the North and conquered Britain, France, Spain, Germany, and even, in the Homeric age, the Greeks, are, the anthropologists would have us believe, a dying race. They are dying out in the towns, and the fresh country blood which is ever setting townwards cannot supply the loss. In a century or two the Angli will no longer be "angeli," but—shall we say—"diaboli"? The smoke, confinement, and irksomeness of town life kills the progeny of the Vikings. If this is indeed so, and there is much to be said in favour of the observation, the outlook for the English is bad. For the change in complexion connotes a change in disposition. The fresh-blooded, eager, restless Northerner will give place to the quiet, inoffensive, humble, short, black-haired Southerner, who can live better under urban conditions. It will be a pitiable thing if the children of the sea-kings cease to be the rulers of their own country and their own empire.

### LEADING ARTICLES.

TUBERCULOSIS AND BRITISH FARMING INTERESTS.

THE issue of the third interim report of the Royal Commission appointed to inquire into the relationsof human and animal tuberculosis marks a further advance in our knowledge of an important subject. Readers may be reminded that the train of eventswhich issued in the Royal Commission originated in the statement of Koch, at the International Medical Congress held in London in 1900, that bovine and human tuberculosis were essentially distinct. Coming from so great an authority, a deliberate utterance of that kind naturally gave riseto world-wide discussion. In England the proposition was at once challenged, and a Royal Commission appointed in August, 1901, with the following terms of reference:—To inquire and report with respect to tuberculosis-

- 1. Whether the disease in animals and man is oneand the same.
- 2. Whether animals and man can be reciprocally infected with it.
- 3. Under what conditions, if at all, the transmission of the disease from animals to man takes place, and what are the circumstances favourable or unfavourable to such transmission.

As regards the first and second terms of the reference, the Commissioners have in their previous reports proved that tuberculosis in the lower animals and in man is essentially one and the same disease, and that the lower animals and man can be reciprocally infected with it. It is hardly possible to overestimate the importance to the community of a conclusive solution of these questions. The Commissioners themselves emphasised various conclusions that must at once follow: - "A very considerable amount of disease and loss of life," they say, "must, especially among the young, be attributed to the consumption of cow's milk containing The milk coming from such a tubercle bacilli. cow ought not to form part of human food, and, indeed, ought not to be used for food at all. Our results point to the necessity of measures morestringent than those at present enforced being taken to prevent the sale or the consumption of such milk." In spite of the publication of that weighty and authoritative warning some time ago, it cannot be said that the State has so far addressed itself seriously to the stamping-out of tuberculous cattle.. The nation goes on subscribing to hospitals and. sanatoria, while the farmers go on distributing tubercle in wholesale fashion throughout the kingdom. The third report is concerned with the third reference. The investigations upon which it is based were carried out by Dr. F. Griffith, upon tuberculous animals purchased by the Commissioners. Tuberculosis of the udder is common, and the milk of cows thus affected always contains: tubercle bacilli. It is now shown that the milk of cows suffering from general tuberculosis, but without local affection of the udder, is at times capable of setting up tuberculosis in guinea pigs. fæces of five out of six tuberculous cows were foundto contain living and virulent tubercle bacilli. Thebearing of this fact upon cow-keeping, both in town and in country, is obviously a fact of first importance. In many ways this little Blue-Book of

thirty-eight pages, constituting the third interim report, is the one that should lead to the practical reform which is the great essential characteristic of British hygiene. One immediate demand will be instruction for our farmers in the whole theory of infection and its prevention, for without the intelligent co-operation of the farmers it will be hopeless to expect any really comprehensive solution of the tuberculosis problem. Anyone who is acquainted with the farming methods of our countrymen will recall a thousand ways in which the infection from tuberculous cows may be communicated to other cows, not to mention pigs, which are often fed with milk from sick cows, and the hundred and one ways in which the milk, even from healthy cows, may become contaminated with tubercle bacilli before it leaves the farm or the town byre. It is to be hoped that the legislature will lose no time in acting upon the information presented by the Royal Commission. It is useless to bewail the scourge of tuberculosis, that forms so serious a drain upon the resources of the nation, unless we take steps at the same time to rid the kingdom of every tuberculous cow within its four corners. Nothing short of rigorous and absolute extermination will meet the necessities of the case. The cost, it is true, will be great, for nothing of the kind could be attempted without compensation to owners. At the same time, the loss to the country would be comparatively small to the destruction of life and health that is going on to a relatively enormous extent year after year owing to the increasing infection of human beings with animal tuberculosis.

### STATE INSURANCE.

Considerable pressure has lately been exercised by the Labour party to induce the Government to start a system of State insurance, and even to make it compulsory on employers to insure their workmen under it. The Home Secretary and the Chancellor of the Exchequer are understood to view the proposal favourably, so much so, indeed, that the great friendly societies are somewhat alarmed lest their domain should be trespassed upon. Last week a declaration by Mr. Lloyd George was read at an Oddfellows' dinner at Warwick, in which occurred the words: - "The Chancellor of the Exchequer asks me to say that in any action which the Government may adopt in regard to insurance against sickness, invalidity, &c., the greatest care will be taken to safeguard the interests of the great friendly societies. Mr. Lloyd George fully appreciates the excellent work which is being done by these societies, and in any scheme which may be devised for supplementing it, has always recognised the importance not only of interfering as little as possible with their present activities, but also of strengthening and encouraging them by every possible means. He is of opinion that these societies form such an invaluable agency of national thrift that it would be a misfortune indeed if anything were done to impair their utility." Now, although with the business of insurance as such medical men are not concerned, yet in the details of any scheme dealing with life, sickness, or accident insurance they will necessarily be intimately associated. We need hardly discuss the question whether such insurance is likely to be done better by the State than by commercial companies. It is, however, pertinent to point out that the present Government plans of life assurance and annuity business are not nearly so attractive as those offered by sound companies which trade for profit. The reason is not difficult to find, for the fact remains that red-tape and absence of stimulus are bound to have a retarding effect in all State concerns. The stability of an insurance office, when well established, is as sure as that of the Exchequer, and enterprising managers make it their business to suit their policies to all the exigencies of national and domestic life. But if the State takes on the work of insurance as proposed, especially if compulsory insurance is insisted on, the interests of medical men must be properly safeguarded. It is held by the Labour party-and in that particular we are in thorough agreement with them-that the State should be a model employer, and that the hours worked, the rate of wages, and the conditions of employment should be those determined by consent with the trades unions, that is, with the representatives of the employées. When the insurance scheme is being prepared, especially in a lean financial year like the present, there will be a determined attempt to cut down the cost of administration, and very properly so. At the same time, the just demands of the medical profession in the way of conditions of employment and of fees must be regarded. The experience of the past has taught us that such interests are grossly neglected in all relations of the State and the profession, whether it be in regard to death certificates, notification of births, or what not. We feel justified in thus early calling the attention of the Chancellor of the Exchequer to this aspect of the matter. It is one which probably has not yet come under his notice, and will, as likely as not, be regarded as a minor point of detail which can be scrambled over without exciting general hostility. We have no doubt, however, that Mr. Lloyd George, who showed himself so wise and fair an administrator at the Board of Trade, is not the man wilfully or lightly to disregard any just claim or fair interest, and he will be well advised to place himself in free communication with representatives of the profession, not necessarily those of the consultant type, and to obtain their views as to conditions acceptable to the medical practitioners. The difficulties of grafting such a scheme on to the present ramification of the insurance business will not be few nor light, especially if the Workmen's Compensation Act, with its many administrative defects, be left unamended; and those difficulties will be enormously multiplied unless the willing co-operation of medical men is obtained. In such work as insurance there does not even exist the question of humanity or good feeling which is always urged as the excuse for imposing burdens on medical practitioners. It is a matter of pure business, and must be dealt with on pure business lines.

### CURRENT TOPICS.

### Report of the Registrar-General for England and Wales, 1907.

THE Seventeenth Annual Report of the Registrar-General, covering the year 1907, contains some noteworthy facts in vital statistics. The feature

likely to attract most attention is the progressive fall in the birth-rate. Since registration became effective the highest point was attained in 1876, when the rate was 36.3 per 1,000 living of the population. Since that year a steady decrease has been registered, and now has fallen to the lowest point on record, namely, 26.27 in 1907. While it would be idle to deny that this state of affairs demands serious consideration, there are, nevertheless, other elements in the situation which suggest that the outlook may be less gloomy than present appearances suggest. Both marriages and births are influenced by the state of the national prosperity, which for some years past has been in a depressed condition. More important, however, are the steady declines in the general and the infantile mortality rates, both of which have in 1907 touched the lowest point hitherto recorded. total result, measured positively, is a lessened rate of mean annual increase in the population of England and Wales to the extent of .42. In the quinquennial period 1876-1880, the average increase was 14.56, which fell to 11.77 in the period 1891-1895, and has thence fallen with slight decimal fluctuations to 11.27 in 1907. At the same time, the mean annual death-rate has fallen from 20.79 in 1876-1880 to 15.00 in 1907. But, as the Registrar-General remarks, while the decrease in births may reach vanishing point, there must be a finality in the decrease of deaths. The decline in infantile mortality is a striking and gratifying feature of the Report. The rate for 1907 is no less than 30 per cent. below the average of the period 1861-1865, the reduction being equal to 28 per cent. amongst males and 32 per cent. amongst females. According to the Registrar-General, this decline has resulted from the passing of the Public Health Act in 1875, by advances in medical science, and by the increased attention paid to hygienic matters by the individual, by local authorities, and by the State. The deaths of infants under one year of age registered in 1907 numbered 109,978, a proportion of 118 per 1,000 births, as against 132 in the preceding year, and an average of 145 in the ten years 1897-1906. As in the general mortality returns the average is seriously diminished by the operation of unfavourable local returns. This point is referred to by the Registrar-General as follows: - "There are several areas in this country, both urban and rural, where the rates are low, and compare favourably with the lowest recorded in the several foreign and Colonial States. On the other hand, there are many industrial centres where the excessive rates indicate that the conservation of infant life is much neglected. It may confidently be affirmed that in future any permanent reduction in the mortality of young children in England and Wales as a whole will largely depend upon a due recognition of parental responsibility on the one hand, and on the other an improved health administration in these industrial areas, particularly in that of numerous small towns." Finally, it may be said generally that, in spite of the falling birth-rate, it is satisfactory to find that the annual mean increase has not materially altered during the past eighteen years. Another noteworthy point in the report is the fact that for the first time for many years there has been a break in the increase of cancer mortality. Amongst children measles has caused more deaths than usual, and scarlet fever, diphtheria and diarrhoeal diseases have been less fatal. The marriage-rate has shown a considerable fall. On the whole, the latest figures of the Registrar-General are distinctly encouraging, although, as we have already pointed out, their full significance cannot be revealed without skilful and painstaking analysis.

### A Notification of Births Prosecution.

An interesting case came before the Belfast Summonses Court last week, in which a midwife and the father of a child were summoned by the Corporation for having failed to notify a birth within twenty-six hours. The midwife testified that the birth took place on October 30th, 1908. The Notification of Births Act was adopted by the Corporation in December, 1907, and came into force in February 1908. Due notice was given to medical men, but the authorities were unable to give notice in writing to the midwives, because they are not registered in Ireland. Special advice, however, had been given to the midwife concerned, and a public warning was published in the newspaper on lune 18th, 1908. It was officially stated in evidence that there was a failure of 30 per cent. in the notification of births, and the authorities were determined to prosecute. In the case under consideration the knowledge of the child's existence was brought to the knowledge of the authorities only when the child was attacked with cerebro-spinal meningitis, and a notification was sent in by the medical attendant. The father pleaded ignorance of the Act, and this being the first prosecution of the kind, no penalty was inflicted, but a fine of five shillings and costs was inflicted upon the midwife. As it was shown clearly in evidence that the midwife had been personally warned as to her responsibility in the matter, she may congratulate herself on having got off so lightly. It seems evident that something more should be done to educate the public as to the meaning of the Act, which in many cases is hopelessly muddled up with that for the registration of births.

Property in Patients.

THERE is a lot of nonsense talked by medical men as regards imagined property in patients, when they come to discuss points of professional ethics. As Mr. Justice Lawrance put it the other day, in summing up the evidence in an action for libel between medical men: - "There was one thing they had learnt from the case, and he thought it would be very useful to all of them: they must remember that when they went to a doctor he thereby acquired some interest in them until the day of their death. It might be desirable, when one went to a doctor, to begin with the remark, 'I am a patient without prejudice.' If they did not say that the doctor might pursue them to the end of their lives." This is very cutting, but we fear we have brought it on ourselves. Many medical men seem to think that once a patient has sought advice from a medical man, he has no right toseek advice elsewhere without express permission. It seems hardly likely that the choice of the public can be thus limited. Let it be said at once that a medical man has no more property in his patient than a lawyer in his client, or a grocerin his customer, and a member of the public is just

as free to choose or change his medical adviser as his man of business, or his grocer. There is, it is true, this difference, that whereas a man may have two grocers at any time, he cannot, from the nature of the case, have two doctors attending him independently for the same ailment, any more than he can commit the charge of a piece of legal business to two solicitors at the same time. We are saying nothing in the slightest degree to excuse the interference of one medical man with the relations between another and those who are, or have been, in his medical care. Such interference is, like other forms of touting for practice, unprofessional in the highest degree.

### The Care of Sane Epileptics.

THE Philanthropic Reform Association had under consideration at its annual meeting the question of the care of destitute and sane epileptics who at present are to be found in workhouses. There are in Irish workhouses between 400 and 500 sane epileptics who are segregated with lunatics and idiots, and whose mental condition has been in many instances seriously affected by their surroundings. In 1901 the Countess of Meath offered a sum of £5,000 towards the initial expenses of building a central home in Ireland for sane epileptics. The offer, however, depended on the amount of support forthcoming from the boards of guardians, which would be expected to contribute to the support of any patients sent by them to the home. The guardians, however, did not give the necessary undertakings, and the offer, though not withdrawn, has not led to any practical results. The Philanthropic Reform Association has decided to ask the Government to make a grant of four shillings per head per week towards the maintenance of every destitute sane epileptic maintained in any home certified by the Local Government Board for Ireland. A very small support from the rates would then enable such homes to be worked satisfactorily, and thus provide reasonable comfort for these unfortunate people. It would also, as Lord Mayo pointed out in proposing the resolution at the meeting, tend to prevent them from becoming inmates of asylums by helping to preserve their mental faculties.

### PERSONAL.

THE PRINCESS OF WALES, on behalf of the National Hospital for the Paralysed and Epileptic, Bloomsbury, has consented to receive purses in aid of the Jubilee Fund some time during the autumn. The amount aimed at by the Jubilee Fund is £50,000, of which £10,000 is to be devoted to the extension of the premises, a commencement of the building having just been made.

Dr. J. E. Gordon has been appointed to the post of Medical Superintendent of the Devon and Cornwall Sanatorium.

Mr. A. G. R. FOULERTON, F.R.C.S., has been appointed Milroy Lecturer at the Royal College of Physicians of London for 1910.

AT a meeting of the Rhondda Education Committee, Dr. J. W. Glenton Myler, of Cardiff, was appointed Medical Examiner of School Children at a yearly salary of £250, rising by annual increments of £25 to £350.

At the annual meeting of the governors of the West Wales Sanatorium, which was held at Carmarthen, under the presidency of Sir James Williams-Drummond, Bart., Lord-Lieutenant of Carmarthenshire, Dr. Bowen Jones received a handsome presentation in recognition of his work for the institution.

AT a meeting of the Senate of the University of London, held on January 27th, the Vice-Chancellor, Sir William Collins, M.D., M.P., in the chair, Mr. G. H. Cowen, M.B., M.S., was appointed member of the Council of Hartley University College, Southampton, and Mrs. Scharlieb, M.D., M.S., Governor of St. Mary's College, Paddington.

Miss Muriel Robertson was appointed at the same meeting to be one of the assistants to the Professor of Protozoology in place of Dr. J. D. Thomson, resigned; and a letter was received from Dr. P. H. Pye-Smith, M.D., F.R.C.P., F.R.S., intimating his resignation of his membership of the Senate as one of the representatives of the Royal College of Physicians of London.

On February 2nd, the Director-General of the Royal Army Medical Corps and the members of the Royal Army Medical College entertained at dinner Viscount Midleton, who, as Secretary of State for War, founded the college. Amongst other guests present were Sir William Nicholson. Chief of the General Staff; Sir Herbert Miles, 'Sir A. Wynne, General Browne, Sir James Crichton-Browne, and Lord Edmund Talbot.

THE Presidential Address at the next annual meeting of the British Medical Association will be delivered by Sir William Whitla, M.D., LL.D., Professor of Materia Medica and Therapeutics, Queen's College, Belfast; the Address in Medicine by Frederick Taylor, M.D., F.R.C.P., Consulting Physician, Guy's Hospital; the Address in Obstetrics by Sir John Byers, M.D., Professor of Midwifery and Diseases of Women, Queen's College, Belfast; and the Popular Lecture by J. A. Macdonald, M.D., M.Ch., Physician to the Taunton and Somerset Hospital, Chairman of the representative meeting.

The following Fellows of the College of Physicians have been elected Councillors: Sir William Allchin, in the place of the late Dr. C. E. Beevor; Dr. Sidney Phillips, Dr. W. Pasteur, Dr. S. Martin, and Dr. A. E. Garrod, in the place of Dr. W. Osler, Dr. Crocker, Dr. Tooth, and Dr. Acland, who retire by rotation.

At the same time Dr. F. H. Champneys was reelected to represent the College on the Central Midwives Board; and Dr. C. Theodore Williams was elected a representative on the Court of Governors of the University of Birmingham.

AT a large gathering of those interested in ambulance work at Oxford, Dr. J. C. R. Freeborn, the chief Honorary Surgeon of the corps, was made the recipient of a presentation which had been subscribed for by friends and pupils.

MAJOR RONALD Ross, Professor of Tropical Medicine in the University of Liverpool, has been invited by the Governor of Bombay to proceed to that city to take part in the deliberations of the Indian Medical Congress. The committee of the school have arranged for Major Ross to accept the invitation, and he left for Bombay on February 3rd.

### A CLINICAL LECTURE

ON

### INTUSSUSCEPTION. (a)

By DENIS KENNEDY, F.R.C.S.L.,

### Surgeon to Jervis Street Hospital and to the Children's Hospital, Dublin.

Intussusception is a form of intestinal obstruction that has a very high mortality. This high mortality can be accounted for :-

(1) The disease usually occurs in infants or young

children.

(2) The diagnosis is not made sufficiently early for treatment to be effective.

(3) Purgatives are frequently administered be-

cause of faulty diagnosis. (4) Valuable time is sometimes lost in treating the disease by measures that will almost certainly

be ineffective. Varieties of Intussusception .- There are four

varieties of intussusception:

(a) Enteric—when the trouble is confined to the small bowel.

(b) Colic—when the trouble is altogether in the large bowel.

(c) Ileo-colic-when the ileum slips into the colon through the ileo-cæcal valve, and the intussusception is increased at the expense of the small bowel.

(d) Ileo-cæcal—when the ileum and cæcum, preceded by the ileo-cæcal valve, with, of course, the vermiform appendix, slips into the large bowel, and the invagination is continued entirely at the expense of the colon. This is the most common variety, and constitutes close on 40 per cent, of the cases.

Ætiology.—Sometimes intussusception is started by a polypus in the lumen of the bowel; sometimes it may be caused by intestinal worms; sometimes by the increased peristalsis associated with acute enteritis; but in a large number of cases one cannot say what really is the exciting factor in the disease. In all cases it is impossible to recognise the presence of the cause until the intussusception has occurred. Hence, as clinicians, we are principally concerned with the pathological changes that take place, with the symptoms that are produced, and with the best

means of saving our patient's life.

Pathological Changes.-The first essential pathological change that occurs is the invagination of the bowel above into the lumen of the bowel below. This can be easily illustrated with the finger of a kid glove. In the process of invagination serous surface is opposed to serous surface, and mucous surface to mucous surface. On a transverse section there will be three concentric rings of bowel, and, of course, there will be three layers of intestine on either side of the central canal. The outer layer of bowel is called the intussuscepiens, or sheath, and the middle or returning layer, with the inner layer, constitute the intussusceptum. In all varieties, with the exception of the ileo-colic, the invagination progresses at the expense of the "sheath." Thus, in the ileo-cæcal variety the ileocæcal valve may protrude through the anus, the Intussusception having progressed at the expense of the colon. Other important pathological factors must also be considered. The invaginated bowel is practically in a condition of strangulation. The mesentery being drawn with the bowel, its blood-

A point not to be forgotten is, that the longer an intussusception is left unreduced, the more difficult reduction becomes, and ultimately reduction will become utterly impossible. This is brought about at first by the swelling of the invaginated bowel on account of its strangulation, and later by adhesions that form between the opposing surfaces of in-

testine.

The intussuscepiens, or sheath, does not undergo gross pathological changes. It becomes congested, more friable, and is very easily torn in attempts to

reduce the intussusception.

Symptoms.—The gravity of the initial symptoms depends, as in all sudden abdominal lesions, on the amount of injury done to the viscera involved; in other words, on the amount of bowel invaginated. Consequently, in some cases the early symptoms may not be severe, and the diagnosis symptoms may not be severe, and the diagnosis may be missed. Sudden pain in the abdomen, associated with more or less collapse, occurring in a child that has been previously healthy, should always make us suspect the trouble. In an infant, unaccountable fits of crying with great restlessness are the early symptoms. When the disease is developed we get the typical symptoms of intestinal obstruction, as far as regards the collapsed condition of the patient, the facial aspect, and the continuous vomiting. But there are a few well-marked symptoms that will differentiate intussusception from any other abdominal lesion :-

(1) There is the frequent passage per anum of blood and mucus, and, consequently, instead of getting a history of constipation, we get the opposite, of diarrhœa.

(2) There is always present an abdominal tumour.

There is tenesmus.

(4) Vomiting in the beginning, at all events, is not persistent and does not become fæcal for a considerable time. (5) The intussusception may be felt on making a

digital examination of the rectum.

vessels become subject to pressure at the neck of the intussusception. At first this pressure is only sufficient to interfere with the return of venous blood. In consequence, the invaginated bowel becomes engorged with blood and greatly swollen; hæmorrhage occurs from the engorged blood-vessels into the lumen of the bowel, and this hæmorrhage, which becomes mixed with the increased mucus that is poured out from the congested mucous membrane of the intestine, is passed per anum, and forms the discharge, "bloody mucus," which is so characteristic of the disease. As the swelling of the intussuscepien increases, the pressure on the mesenteric vessels will become greater, and after some time the arterial supply will be completely cut off. The intussuscepted gut becomes strangulated, gangrenous patches will then appear on the invaginated bowel, and finally sloughing of the whole mass may ensue if the patient lives for a sufficient time. In this way Nature can possibly effect a cure; but so rarely does this event occur that we must not allow it to enter into our minds in the treatment of the disease.

<sup>(</sup>a) Delivered at the Jervis Street Hospital, November 3rd, 1908.

(5) The abdomen does not become distended, as a rule.

The key to making an early diagnosis is the palpation of the abdominal tumour. As I have said, it is always present, but usually can be felt in the early stage of the disease, only on the administration of an anæsthetic-chloroform for choice. By giving the suspected child chloroform, and by making a careful abdominal and rectal examination, we can be as certain of the presence or absence of intussusception as if we made an exploratory laparotomy, by the presence or absence of this abdominal tumour. It is the absence of this examination with the patient anæsthetised that accounts for the large number of cases of intussusception that are not diagnosed until it is too late for treatment to be effective. I well remember the case of a little boy, three years old, who was brought to three general hospitals in the city, and two practitioners, during three days. In each place either a purgative or astringent was ordered. The little patient, not improving, was brought to a maternity hospital, where the condition was accurately diagnosed, and the patient was sent at once to the Children's Hospital for operation. I operated the same night, but, needless to add, I was unable to save the patient's life.

Prognosis.—The prognosis depends on the disease being diagnosed early, and on the patient being promptly and efficiently operated on. In the absence of early operation, the disease is nearly invariably fatal in a few days. The age of the patient must be taken into consideration, as young infants under six months old stand abdominal operations badly.

TREATMENT.

In treating intussusception, the practitioner must remember that there are things he must not do, as well as things he must do. He must not give purgatives. Castor oil or calomel is frequently ordered, because the condition is mistaken for acute enteritis. Secondly, the less nourishment that is given by the mouth the better. Unless a sip of water, nothing else is admissible.

With regard to what ought to be done, I am firmly convinced that the only satisfactory or effectual treatment is operative. The abdomen should be opened and the invagination reduced manually. In reducing the intussusception, care must be taken to be as gentle as possible; it is easy to tear the intussuscepien. The best way to effect reduction is by pressing back the invaginated bowel, beginning at the apex. Previous to operation, but when the case has been diagnosed, a hypodermic of morphia may be given with advantage. It relieves pain and checks peristalsis, which will prevent the intussusception being increased. It must, however, be borne in mind, that children bear morphia or opium badly.

bear morphia or opium badly.

I do not think it possible for an intussusception to be reduced by the injection of air or gas or water through the rectum. When anyone who has frequently operated on these cases sees the difficulty of reducing the invagination, even when the abdomen is opened, he must come to the conclusion that reduction by means of anything injected through the rectum is utterly impossible. There are two dangers in connection with these attempts at reduction by injections through the rectum: One: valuable time is lost and false hopes are held out to the patient's parents; the other: it is not unknown for the bowel to have been ruptured by the pressure of the injection being too great.

With regard to what ought to be done if the reduction of the intussusception is impossible, I think no hard and fast rule can be laid down.

Every case will have to be treated on its own merits. The age of the patient, the amount of collapse, the length of time elapsed since the beginning of the illness, the condition of the bowel involved, will all have to be considered in coming to a decision.

One of three or four procedures may be carried

(1) Resection of the irreducible mass and making an artificial anus.

(2) Resection of the mass and performing an anastomosis, either end-to-end, or lateral.

(3) Where the invaginated bowel is not gangrenous, nor liable to become so, as sometimes occurs in chronic intussusception, a short-circuiting of the bowel can be done by an anastomosis between the bowel above and the bowel below, leaving the irreducible intussusception alone.

leaving the irreducible intussusception alone.

(4) Probably the operation that will be applicable to the greatest number of irreducible cases is that known as Jessett's or Barker's. The principle of this operation consists in splitting the intussuscepiens on the anti-mesenteric border of the bowel, cutting away the intussusception right to the neck; then the edges of what remains of the middle and internal layers are sutured together. This checks any bleeding that may occur. The operation is completed by suturing the opening that was made in the intussusceptiens. It is the most rapid method of dealing with an irreducible intussusception, and at the same time having an efficient restoration of the continuity of the bowel.

In any operation for intussuception we must deal with any abnormal condition that may have been the cause of the trouble. If a polypus is felt in the lumen of the bowel, it must be removed; or if a Meckel's diverticulum is present it should be resected.

Special precautions should also be taken to prevent shock. The limbs and chest of the patient should be swathed in absorbent wool; the operation should be carried out rapidly, as a child bears a prolonged operation very badly; no unnecessary handling of the small intestine should occur, and on no account should evisceration be allowed to take place. Sometimes in a young child it is difficult to prevent some of the distended coils of intestine becoming protruded when the abdomen is opened; this is especially the case if the child is not completely anæsthetised. If escape of some intestine should occur, it should be wrapped round with gauze wrung out of hot saline solution, until its return can be completely effected.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Prof. H. Chauffard, M.D., Physician to the Paris Hospitals. Subject: "Moningeal Hamorrhage."

International Congress of Ophthalmology.

WE are asked to intimate that an effort is being made to arrange special terms for travelling expenses and hotel accommodation for the benefit of those who may wish to attend the above Congress, which will be in session at Naples from March and to April 7th. We would also remind our readers that it is proposed to issue for perusal before the meeting the communications which are offered for discussion at Naples. These will only be sent to those who have signified their intention to be present and have paid the Congress subscription in advance (25 francs for members and 10 francs for each accompanying member of a family). To facilitate these arrangements it is most desirable that those who wish to attend should make the earliest possible intimation to one of the corresponding members for Great Britain and Ireland: Walter H. Jessop, 73 Harley Street, London, W.; Dr. George Mackey, 20 Drumsheugh Gardens, Edinburgh; or Sir Henry Swanzy, 23 Merrion Square, Dublin.

### ORIGINAL PAPERS.

A CONSIDERATION OF SOME OF THE MORE RECENT WORK ON

### IMMUNITY, ESPECIALLY IN RELATION TO DIAGNOSIS AND TREATMENT. (a)

By Prof. ROBT. MUIR, M.D. Ed., F.R.C.P.E.,

Professor of Pathology in the University of Glasgow.

PROFESSOR MUIR commenced his paper by stating that immunity to ordinary infections is due to two things, namely: (1) reactions on the part of the cells of the body, and (2) resulting changes in the serum of the blood. Regarding the nature of the first of these we know practically nothing, in fact, nearly all the recently-acquired knowledge on this subject is with regard to the changes that take

place in the blood serum.

After pointing out that not only bacteria themselves, but the toxins they gave rise to, were very complex bodies, and that no anti-substances could be formed in the blood to any substance of known chemical constitution, the lecturer described the condition of immunity, and contrasted it with the condition we are familiar with as tolerance. Tolerance was a kind of acclimatisation either to surroundings or to conditions that were normally injurious; or to taking substances into the body that acted in an injurious manner upon the tissues. In tolerance there are no anti-substances formed in the blood. In immunity, on the other hand, anti-substances which neutralise the effects of bacteria or of their toxins are formed in the blood, and the condition of immunity to infection depends upon their action. The molecules which give rise to anti-substances are generally known as antigens. Not all toxins have anti-substances formed when they get into the blood, so that, as far as is known, there is nothing that can neutralise the harmful effects of some bacteria. Toxins which act as antigens soon disappear from the blood after being injected; this is largely due to their combining with or fixed to the cells of the body. The anti-substances then begin to develop in the blood serum. These neutralise the effects of the toxins and bring about a state of immunity, which may last for a very long time after the anti-substances have all disappeared from the blood. This state of immunity consists of several well-defined periods. There is first a latent period during which the toxin is be-coming fixed. This is followed by a period of rapid formation of anti-substances. Then there is a period during which this condition is maintained, which is followed by a period during which antisubstances are formed more and more slowly, and gradually disappear from the blood entirely. again is followed by a period of immunity during which no anti-substances are found in the blood. The crisis in infectious diseases probably corresponds to the second period of immunity, when the anti-substances are rapidly formed.

When anti-substances are being developed, say, in response to the injection of toxin, the state of immunity can be greatly increased by the injection of moderate doses of the toxin at intervals. In this increase or intensification of immunity there are two phases, a positive and a negative. The injection of a moderate dose of toxin is followed by the negative phase of immunity. This is a diminution in the amount of anti-substances in the blood, caused by the direct neutralisation of a portion of the anti-substances by the new antigens injected. It

(a)"Abstract of, paper read before the Glasgow Medico-Chirurgical Society, January 22nd, 1909.

does not go the length of making the state of immunity disappear, but simply causes a depression which is soon followed by the positive phase of immunity. During this phase anti-substances are formed in greater quantity than before, so that the condition of immunity is exalted to a higher level than it reached before the injection of the toxin. This can be repeated at intervals till the state of immunity is very high, as long as only moderate doses of the toxin are used. When a large dose of toxin is injected the effect is different, for the result may be a negative phase only, which may be so great that it may cause complete failure in the formation of anti-substances.

The changes that take place in the cells of the body, which keep up the condition of immunity after the disappearance of anti-substances from the blood, are comparatively unknown; the discussion of the possible explanations must be left over. The anti-substances are, therefore, substances which are formed in the serum of the blood as a reaction to toxins, &c., and they are only formed when the toxin has certain molecules in its composition, which act as antigens. It is therefore the antigens that give rise to the anti-substances. This relation of antigen to anti-substance is one of specific combining affinity. Only one particular anti-substance can be produced as the result of the presence of any particular antigen in the blood. This specificity particular antigen in the blood. is remarkable, and is the outstanding feature of the phenomena observed in the production of immunity, though the nature of the combination is still the subject of controversy. While the nature of the anti-substance never varies when any particular form of bacterium or toxin is injected into the blood, the quantity of the anti-substance varies greatly in different individuals and in different The amount of anti-substance developed may be in great excess of the amount of toxin or antigen introduced into the body—a fact of which no satisfactory explanation can be given.

In contra-distinction to the condition of immunity, there is a condition called anaphylaxis. This is a state in which the cells of the body are hypersensitive to infections, that is, there is a diminution of the normal resistance to the action of bacteria or other toxins. It is different from what we understand by idiosyncrasy, and different also from what we regard as the cumulative effect of injurious substances introduced into the body. exact nature is still unknown, but in this condition there is in the tissues of the body a want of resistance to the action of bacteria or their toxins. This condition can be brought about by the injection of small quantities of toxin at intervals; thus, very small doses of the diphtheria toxin injected at intervals may cause a marked hypersensitiveness to the diphtheria toxin. A condition allied to anaphylaxis is well marked in patients who are suffering from any form of tubercular disease, as both the tuberculin reaction of Koch and the ophthalmic reaction of Calmette depend on it for their diagnostic value. The reactions in these tests are due to the excessive sensitiveness of the tissues to the action of the tubercle toxin, when there has been small quantities of this present in the tissues for some time. All the tissues of the body are rendered hypersensitive by the action of the toxin in tubercular patients. The "Theobald Smith phenomenon," which consists in the extraordinary sensitiveness produced in the guinea-pig to horse serum by the previous injection of a minute quantity of the serum, was also referred to as the most remarkable example of anaphylaxis.

There are two different kinds of immunity, or two different ways in which immunity may be brought about, depending on the source of the anti-

substances. When the anti-substances are developed in the immune animal itself the resulting condition is called active immunity. When the anti-sub-stances are not developed in the immune animal, but are transferred from another animal to the immune animal, the resulting condition is called passive immunity. Active immunity is produced by vaccines, which are a modification of the virus that causes the disease; and this immunity by vaccines is used as a prophylactic measure in such diseases as plague, typhoid and cholera. In this method of producing active immunity, cultures of the bacteria that cause the disease are used in small quantity, and these may be dead, as in plague or typhoid, or they may be living, as in cholera. The small quantity of virus introduced into the body is capable of giving rise to a large amount of anti-substance in the blood, and these anti-substances which accompany the condition of immunity can be observed, differentiated, and measured.

There are found to be five different varieties of

anti-substances, and these differences depend on the nature of the action of the anti-substances. varieties are, namely: (1) Anti-toxins; (2) precipitins; (3) agglutinins; (4) opsonins; (5) immune bodies. The agglutinins, opsonins, and immune bodies are all produced by the presence of bacteria in the blood. Their presence and amount can be readily ascertained, and they are of considerable value in diagnosing and prognosing several im-

portant diseases.

(1) Anti-toxins are anti-substances which unite with the corresponding toxins and render them inert; the most important example is the anti-toxin

example of diphtheria.

(2) Precipitins are formed in the blood of one animal by injecting the serum of another animal of a different species. For every species of animal the reaction is comparatively specific. This specificity is very remarkable, and advantage of it is taken to determine the source of blood in blood-stains for forensic purposes. The reaction is obtained by using the very minutest quantities of the animal's blood.

(3) Agglutinins are formed in the blood by the presence of bacteria in the body. The reaction is very marked, and may be present as early as the fifth day in typhoid fever. It is very delicate, and an important diagnostic test; but while the agglu-tinins indicate the presence of the virus, they pro-bably do not destroy the substance causing the disease.

- (4) Opsoning are anti-substances developed in the blood which enable the phagocytes to devour the bacteria when present. They are of two chief types, namely: (a) The opsonins of normal sera; and (b) the opsonins of immune sera, which differ from those of normal sera in withstanding heat, and in being specific. The presence of opsonins in the blood is necessary for the occurrence of the phenomenon of phagocytosis. Under the stimulus of the opsonins of normal serum the phagocytes can attack and destroy many foreign substances that may be introduced into the body; but the specific phagocytic activity towards a particular organism is stimulated only by its own specific opsonin formed in an immune serum.
- (5) Immune bodies. These are anti-substances concerned in bactericidal action and hæmolysis, along with the complement of normal serum. This complement of normal serum is essential for the destruction of red blood corpuscles and bacteria, and is easily destroyed by heat. It is brought into union with the bacterium by means of the immunebody, which acts as a link (amboceptor) or as a sensitiser. The presence of the complement is de-tected by hæmolysis; thus, if the red blood corpuscles of one species of animal be injected into

the blood of an animal of another species, the immune-body formed in the serum of the host's blood, along with complement normally present, causes solution of the foreign red blood corpuscles. If, however, the serum of the host's blood be first heated the complement is destroyed, and its power of dissolving the foreign red blood corpuscles is lost by the serum; this power is, however, restored by the addition of fresh normal serum. complement is taken up or fixed when an antigen and its anti-substance neutralise each other; and haemolysis is stopped by the complement being deviated from the red blood corpuscles. Thus a very minute amount of human serum, along with its anti-serum (precipitin), will fix complement, and thus interfere with hæmolysis. The differentiation of the blood of different species of animals for forensic purposes depends on these phenomena, and they are also made use of in the diagnosis of some diseases. In order that an anti-bacterial serum be bactericidal it is essential both that it contains an immune-body which will bring the complement of the person treated into union with the bacterium, and also that this complement should have a destructive action on the bacterium; these conditions are rarely satisfied. (The original complement of the anti-bacterial serum soon becomes destroyed when the serum is kept, and its place has to be supplied by the complement of the person injected.) He then referred to the method introduced by Mackenzie and Martin of treating epidemic meningitis by injecting into the spinal canal some of the fresh serum of the patient. The method is sound in principle, inasmuch as the serum contains immune-body and also complement, and has a direct bactericidal action on the meningococcus; the actual results are also encouraging. The serum diagnosis of syphilis by means of the deviation of complement was then described and explained.

Treatment by Anti-toxic and Anti-bacterial Sera. -Professor Muir then made some remarks on the treatment of diseases by anti-toxic and anti-bacterial sera. He pointed out that it was not every toxin that had an anti-substance developed by its presence in the blood; and even when a toxin had an antisubstance developed, this, to be effective in producing cure, must be used before the toxin gets fixed in the cells of the body; this is the explanation of the comparative non-success of anti-tetanus In speaking of anti-bacterial sera, he serum. stated that the human complement does not kill the staphylococcus, nor does this organism give rise to any anti-substance that can destroy it. Here the complement is not active, and Professor Muir supposes that any benefit derived from the injection of anti-staphylococcus serum is due to the opsonins present in it allowing of greater phagocytosis, and not to any destruction of the virus by substances in

the serum injected.

The opsonic methods of Wright for the production and estimation of active immunity by vaccines during an infection were then considered; atreptic immunity was thereafter explained. This is an immunity depending on the absence of some substance necessary for the growth of the invading organism. Some the growth of the invading organism. Some organisms require a very specialised medium for their growth, and when this is no longer present their activity ceases and they die out. Thus many organisms that produce diseases in man simply die out when injected into animals of other species. This probably accounts for the inability to develop syphilis, for example, in most of the lower animals. The bacillus of influenza will not grow in an agar medium, but if this be smeared with blood it then grows quite well. So cancer from the mouse can go on growing for a time in the rat till the particular substance it requires for its growth becomes exhausted. It then dies out in that animal. The serum reactions were demonstrated as far as possible in test tubes and under the microscope.

### THE AURAL COMPLICATIONS OF IN-FLUENZA AND THEIR TREATMENT.

By HAROLD F. MOLE, F.R.C.S. Eng.,

Assistant Surgeon to, and Surgeon in charge of the Aural Department, Bristol Royal Infirmary.

Now that the influenza season is again upon us, it seems not unfitting to call attention, in a very brief way, to the various ear troubles it may give rise to, especially as these form a fairly frequent complication of this affection. (a) Amongst adults it is one of the commonest causes of suppurative otitis, and probably accounts for more of this trouble in children than is generally supposed; and particularly is this the case in those suffering from adenoids. Common catarrhs, adenoids, measles and scarlet fever are, however, more frequent causes in children. Although there are some peculiarities in influenzal otitis to which attention must be called, there is, however, no very material difference in treatment between it and that due to other specific affections.

Influenza may set up acute otitis media by way of the Eustachian tube, which may be non-suppurative or suppurative, the latter being the more

With regard to the former, the symptoms are acute pain in the ear, with congestion of the drum, and probably blocked Eustachian tube and deafness. The treatment to be adopted will be that of antiseptic sprays or irrigations to the naso-pharynx, leeches to the front and back of the ear (if the symptoms are severe), instillation of a few drops of warmed carbolised glycerine into the meatus, and hot dry applications over the ear. A brisk aperient should also be administered. As the acute symptoms subside, the ear should be gently inflated by Politzerising or catheter—preferably the latter, as it is more accurate, and the force of the inflation can be better regulated.

The evidence of case-histories shows that this acute non-suppurative otitis caused by influenza is not infrequently the precursor of chronic adhesive middle-ear catarrh. It is, therefore, of the utmost importance to treat it with the greatest care in the early stages, and not to let the patient pass from one's hands until cured.

Suppurative otitis media in influenza is often characterised by the extreme acuteness of the process with ecchymosis, and the formation of hemorrhagic blebs on the drum and on the deeper parts of the meatus, and also by its great tendency to involve the mastoid process. Accompanying these appearances are intense pain of neuralgic character, and, of course, deafness, the latter often coming on more gradually than in other forms of otitis. Another peculiar feature is that this pain is not always immediately relieved when the drum has burst or has been incised, which is the case in other forms of suppurating ears. The early treatment of these cases should be the same as mentioned above in the non-suppurative variety. A careful watch must, however, be kept for signs of suppuration, and persisting intense pain or bulging drum should be treated by free incision of the membrane from top to bottom behind the handle of the malleus. This treatment is far better than allowing the drum to perforate, since it is followed by immediate drainage, and healing occurs more quickly

than in the case of spontaneous perforation. As mentioned above, however, the pain may persist for a few days after the incision. The treatment after incision will depend upon the fancy of the surgeon, and the conditions under which it must be carried out. When the surgeon is able to carry this out himself, thorough cleansing and drying of the ear, and packing down to the perforation with a strip of moist antiseptic gauze as often as is necessary, is perhaps the best. This, however, is seldom possible, and when, as more often happens, the patient's friends have to carry out the treatment, I am in the habit of ordering irrigations (not syringing) of warm boric lotion, carried out frequently, a large quantity of lotion being used each time. The frequency with which this should be carried out will depend upon the amount of disphare. If the inciding is free or the amount of discharge. If the incision is free or the perforation large, it is often unnecessary to order any other treatment than this, as the discharge rapidly diminishes, and the perforation heals in a week or two or less. When, however, all the acute symptoms have passed, and the discharge is much diminished but the perforation is sluggish in healing, a little boric powder may be insufflated, or some glycerine of carbolic acid, I in Io, instilled after the ear has been cleansed and dried. When the perforation is spontaneous and small, and especially if it is at the apex of a nipple-like projection of the drum, it should be enlarged by incision; but if this is not indicated, and the perforation is still small, the best plan is to instill proposition of human and the perforation of human and the perforation of human and the perforation of human and the performance peroxide of hydrogen (hydrozone and perhydrol are strong solutions of the same) for fifteen minutes; mop dry or syringe, and then instil for a similar period a few drops of glycerine of carbolic acid, I in 10, or of glycerine of borax with 2 drachms of absolute alcohol to the ounce. Irrigation and syringing are not of much value when the perforation is small; they only cleanse the meatus. After the perforation has firmly healed it will probably be found necessary to carry out a course of inflations through the Eustachian tube for a time, to completely restore the hearing. If there are not, after three weeks of the above treatment, clear indications that the affection is coming to an end and the perforation closing, it must be assumed either that the antrum is not draining properly through the tympanum, or that the mastoid pro-cess is involved. Under these circumstances the antrum must be opened and drained for a time, and the tympanic cavity washed out by this route.

As before mentioned, one of the peculiarities of influenzal otitis is its tendency to involve the mastoid process. This involvement may take place before there is any perforation of the drum, or, indeed, although rarely, without there being any discharge from the meatus. It may involve the mastoid cells without there being any obvious communication with the tympanum, and it may cause rapid destruction of the bone, early exposing the lateral sinus or dura mater, and giving rise to any of the ordinary intracranial complications. The diagnosis of influenzal mastoiditis is not always easy, and it must be remembered that pain and tenderness over the mastoid at the commencement of the ear trouble will often subside under active antiphlogistic treatment if there is a free opening Temperature is very little guide, as in the drum. it is often subnormal, with the mastoid full of pus and carious bone. A persisting tenderness after the first few days with no abatement in the discharge, with or without swelling, and cedema over the mastoid process, indicates operation without delay. In most cases it will be found necessary to remove the whole of the outer cortex of the mastoid from apex to antrum. Should a specially tender

<sup>(</sup>a) "Bristol Medico-Chirurgical Journal." September, 1908.

spot be noticed, this may be explored first, for the abscess may then be localised. I have seen cases in which the mastoid cells were filled with pus and carious and necrotic bone, and the antrum unaffected, and apparently unconnected with them. After removal of the cortex, all diseased bone should be thoroughly scraped away, and the cavity packed with gauze. It will, of course, be understood that in the acute cases I have been discussing the ossicles are not interfered with nor the drum, unless it is necessary to enlarge an opening in the latter. In this short sketch the intracranial complications cannot be discussed.

Finally, there are those cases of post-influenzal deafness which, on examination, are found to be of nervous origin. They are probably due to a neuritis of the auditory nerve, though some are supposed to be caused by changes in the labyrinth. There is not infrequently severe timitus with them. In this case the treatment consists in the administration of strychnine, either hypodermically or by the mouth. The treatment must be persisted in for some weeks, and the quantity increased gradually until a full dose is reached.

entir a run dose is reached.

# THE PHYSIOLOGICAL IMPORTANCE OF THE PROSTATE.

By Prof. C. POSNER, M.D.,

[SPECIALLY REPORTED FOR THIS JOURNAL.]

The results, very worthy of consideration, that the surgical treatment of so-called hypertrophy of the prostate have achieved during recent years, have again drawn attention to the question: What is the true purpose of the prostate gland in the organism? The experiences of surgeons have repeatedly given a direction to our general physiological views, and we ought to again bring to mind the knowledge, far beyond that of the region affected, that the operative treatment of enlarged thyroids has brought to us. As the symptoms of deprivation were the first to throw a light on the action of the normal thyroid, we might expect here that the extirpation of the prostate and the consequences of it would show us in what the function of this organ properly consists—a question to which physiology has hitherto failed to give a perfectly satisfactory answer.

The matter here is indeed not quite so simple as in extirpation of the thyroid. Men for whom it had been decided to remove the prostate were mostly men of very advanced age, and of them it could be assumed, in advance, that those functions that were connected with sexual life were already in decadence, so that their elimination without something further would

not make itself seen.

Then, in the so-called hypertrophy of the prostate the matter was not one of simple increase in size, but of pathological new growths, of tumours, which had at last changed the proper structure of the gland, so that in effect extirpation did not affect this, but a

tumour that had taken its place.

It is very remarkable how slight the symptoms of deprivation usually are in the individual clinical case. In cases that run a smooth course, there is usually nothing to be noticed as soon as the disturbances caused by the wound have passed away. Not only does the bladder regain its full power, even when the patient has been reduced to the use of the catheter for years, but the general condition improves so much that one is justified in speaking of a "second youth" of these patients. And when the sexual functions suffered, so far as they came into consideration, and when, in particular, impotentia generandi set in, we were more inclined to attribute it to unavoidable injury of the exit passages than to a deeper inward disturbance.

The fact that the bladder does not lose its power of closing after extirpation of the prostate is very remarkable. This observation is in unison with what we see in those castrated early (eunuchs): it shows

most decidedly that the prostate, as such, has nothing to do with closure of the bladder. For long it was believed that such a function must be attributed to it—now it seems no longer doubtful that its muscular parts have another purpose to serve, viz., that of ejaculation. Even if prostatectomy has as yet furnished no materials for determining the other functions of the prostate, it has at least given fresh cause for extensive experiments on animals, from which some clearness in regard to the question pending has already been obtained. Even earlier than this, German inquirers—I mention Disselhorst and Steinach in the first rank—have entered upon this path; more recently, and at the instance of Albarran, a large quantity of material in this direction has been brought forward by two Spanish authors, Serralach and Parès, which may be allowed to be a base for hypotheses, even if the conclusions may be not quite indisputable.

First of all, these investigations, as well as the earlier ones, have again brought proof that things are very different in the different kinds of animals, and that, in particular, a remarkable interchangeable relation exists between the prostate and the seminal vesicles; it appears as if these two organs could to a certain extent replace each other. In animals with large prostates the vesicles are almost, if not altogether absent, whilst in animals with small ones they are very strongly developed. It is possible that much of the prostatic preparations in the market is actually prepared from the seminal vesicles! For the study of the symptoms of deprivation it has, at any rate, been shown to be advantageous to consider the two organs as a whole and to extirpate them together.

In animals sexually mature (rats, dogs, etc.), this operation has made its influence appear in the first instance on the spermatogenesis and the potentia. The elaboration of semen ceases and the sexual impulse is extinguished; the secretion given off in attempts at intercourse contains no spermatozoa. Feeding with prostatic substance, however, revives both these functions; they may even revive spontaneously, but the authors attribute this to retained vestiges of tissue and regeneration of the glands. With these varied experiments agreeing in their ultimate effects, the proof was adduced that in the prostate we have a gland with "internal secretion," the action of which on the genital organs proper appears to have been proved.

Are the observations made on the human subject in accord with these discoveries from experiment?

The existence of a mutual interaction between the testicles and the prostate has long been known. I have already mentioned the fact, known to everybody, that in eunuchs the prostate is scarcely developed at all, as normally, it only reaches maturity at the time of puberty, simultaneously with the development of spermatogenesis. On account of this fact the "sexual operation" has long been carried out, from which the surgeon has promised himself that atrophy of the gland, that late in life becomes swollen and "hypertrophied," will take place—a deceptive expectation that I must emphasise, as the growth is not simply glandular tissue, but tumour mass; retrogression may be expected at most when the tumour mass is mostly of an adenomatous nature.

The question seems to me more important whether inversely an affection of the prostate—atrophy of it or aplasia—might lead to arrest of the sexual function

in the human subject.

I shall here at first attribute no importance to the symptoms resulting from ordinary chronic prostatitis so frequently observed, amongst which impotentia cœundi plays an important rôle. Complicated nervous processes of the most varied kind may here be also in play, and when we see that local treatment directed to this, that massage of the prostate, combined with hydrotherapeutic and general strengthening measures, bring about recovery, we may well doubt whether the loss of power can really be reckoned amongst the symptoms of deprivation. It seems to me more necessary in the study of these things, to limit ourselves to the cases in which spermatogenesis also ceases, where deviations from the normal are distinctly present.

In determining the symptom of azoospermia, until lately, we could only examine the ejaculated semen. We had a compound terminal product before us; and when the spermatozoa were absent, we could not decide whether they had not been developed or whether there was some mechanical hindrance to their outward passage. By far the greatest number of cases were easily explainable in the latter way; it was almost always possible to make out some remains of bilateral epididymitis, that simply prevented the passage of the newly-formed spermatozoa. There were also cases in which there was no history or trace of previous inflammation or trace of cicatrix that could cause any obstacle. We first discovered an exact distinction between these two groups, in diagnostic puncture of the testicle, first introduced by J. Cohn and myself. A good deal of experience has shown that by puncture of the testicle we can almost obtain proof as to whether spermatozoa have been formed or not; I have made repeated reports on this subject, but I would also draw attention to the inaugural dissertation of my son, Dr. H. L. Posner, in which, amongst other things, it is shown that in the healthy individual one never looks in vain for spermatozoa in the puncture fluid.

Those cases that give a negative result after explora-tory puncture are the first to interest us. In the dissertation mentioned there are seven such cases. I have observed several more since they were noted. Hitherto we were in some difficulty as to what to advise in such cases; in general we assumed a primary imperfect development of the testicles, a real absence of sperma-togenesis. For some time I have paid special attention to the prostate in such cases, and have found that this was almost always remarkably small, atrophic or aplastic. This being so, we must either assume a common arrest of development, or that the primary seat of the trouble must be sought in the prostate; the absence of the prostatic substance (its glandular part) would then be the cause of the aspermia. The cause for this absence, again, is difficult to determine. I incline to the assumption that there has been in many cases a previous prostatitis, and here I would emphasise that it need not by any means always be of a gonorrhœal nature, but that it may arise through other infections (B. coli), or it may be "aseptic," for example, from simple retention of the prostatic secretion. Stern has observed, to give a clinical illustra-tion, that prostatitis is a very frequent occurrence in diabetics, as I have also shown as regards the so-called prostatic hypertrophy. Is it not likely that the impotentia generandi of these patients may all be explained in the way pointed out? Supported as we are by animal experiment, we shall be justified in drawing therapeutical conclusions from the foregoing. At least in such cases we should try the internal employment of a useful preparation of the prostate, or Poehl's spermine, a medication that should be as rational in such cases as the giving of thyroid is in diseases set up by deficiency of that organ. Although it was observed at the commencement that the symptoms of deprivation were but slight after prostatectomy, in order to avoid misunderstanding, it may be mentioned here that in such cases we have to do mostly with old men, in whom, even without operation, the sexual functions would be failing or lost altogether. It will now be understood that, in spite of escape from injury on the part of the exit passages, impotence may occur, and, on the other hand, power may be retained when residua of the prostate gland are left. Animal experiment appears to show, further, that a close connection exists between the prostate and the bladder; the removal of the prostate causes paralysis of the bladder as a symptom of deprivation. This point is much in need of further clearing up; as, willingly as one would the so-called faux prostatiques of Guyon of patients who suffer from symptoms of prostatismus, in spite of the prostate being remarkably small, in this way, however much Goldberg's group of prostatistis cystoparetica may invite us, we must look, on the other hand, at our surgical experiences. After prostatectomy we see the bladder that has been paralysed for years and dilated to its maximum regain its full muscular strength. Further investigations are required to explain this contradiction, and especially to determine how far the nerves of the prostate are implicated.

Further knowledge of the functions of the prostate should also be expected from the experiments at implantation recently made by Haberer, after total extirpation of the organ. As the locality for implantation in my opinion—after the procedure of Kocher in Basedow thyreoidea—in the dog, the epimetaphesis of the femur should be considered. Neisser has already shown a mutual action between the prost te and bone marrow. No positive results as to the effects of implantation are before us.

In contrast to these questions that are essentially concerned with the subject of "internal secretion," the interest as regards the proper function of the secretion of the gland has dropped behind. The assumption, based on the observations of Fürbringer, that there is some relationship to the vitality of the spermatozoa, is undoubtedly justified; but it is questionable whether the matter is one of simple dilution of the semen (and thus one of osmosis) or of a specific ferment. The presence of lecithin in the secretion of the prostate may be evidence in favour of this; such an excitation is set up by it, as we have learned to recognise lecithin as an exciter of ferment. But we must not look upon this action as something altogether indispensable. I have repeatedly found living spermatozoa in spermatoceles, as well as recently in puncture fluid from the testicle.

In my address before the Paris Congress of Urologists, I pointed out that possibly another function—one little thought of or but little understood—was to be attributed to the prostate. It perhaps represents an analogue of the rut glands so strongly developed in many mammals. That the secretion of the gland is that which gives the specific odour to the semen has been shown by Fübringer; this odorous material has apparently lost its original significance in the human subject, whilst similar substances play a great rôle as sexual exciters in the animal world. I have already observed that (according to Disselhorst), in the hedgehog, for example, the corresponding aromatic substance is actually produced in the prostate, whilst otherwise it is mostly the cloacal glands that are concerned. From this point of view the prostate would

be looked on as a residual organ, that has, perhaps, at one time had higher functions than it has to-day in the human subject.

### **OPERATING THEATRES.**

KING'S COLLEGE HOSPITAL.

**OPERATION** FOR VISCEROPTOSIS.-MR. ALBERT CARLESS operated on a woman, set. 45, who had been sent into hospital with a story of urinary trouble; occasionally she went for a day or two without passing water, and during these periods her doctor stated he was unable to draw off water by catheter, and at the dropped into the pelvis. This was associated with a certain amount of pain and discomfort. This story on the face of it, Mr. Carless remarked, read like that of displacement downwards of a single kidney, followed by kinking of the ureter and dilatation of the pelvis of the kidney, with retained urine. The patient was a well-nourished woman, and had been kept under observation for a week or more. She was made to get up and move about the ward and do some dusting in the hope of bringing about a repetition of the above-stated phenomena; nothing, however, abnormal had occurred. On palpation neither kidney could be felt, and there was no obvious mobility; the abdominal wall, however, was very loose and relaxed, and hung down in a sort of pouch, into which the intestines dropped. It was possible to grasp a large handful of the abdominal wall, and on releasing one's hold the intestines could be felt to drop downwards, with pain in the back to the patient. The woman had had four children, and this condition of the belly wall was the outcome of the pregnancies. Under these conditions, Mr. Carless thought it advisable to deal first with the abdominal wall and tighten it up effectively, taking the opportunity at the same time of exploring the abdominal

The operation was as follows: -A free incision was made in the middle line from a little above the umbilicus to a point just above the symphysis pubis; this incision was subsequently increased upwards. The linea alba was found to be much stretched, and replaced by a fibrous aponeurosis extending between the margin of the recti muscles, which were separated by an interval of two or three inches. The aponeurosis was split in the middle line, and the peritoneal cavity opened. Examination of the abdominal contents revealed the facts that the left kidney was abnormally mobile, but of normal size and with no evidence of hydronephrosis; that the right kidney was normal in size and shape and not unduly mobile; that the gallbladder contained a good many small calculi; and that there was nothing obviously wrong with the rest of the viscera. It was decided merely to deal with the abdominal wall at this operation, and if subsequently symptoms arose the left kidney and gall-bladder would have to be dealt with separately.

The method of dealing with the abdominal wall was as follows: The skin and subcutaneous tissues were separated on each side from the muscles and aponeuroses as far as the linea semilunaris; a silk mattrass suture was then passed through the margin of the aponeurosis representing the linea alba, and the underlying peritoneum and the loose ends carried by a long, full-curved hernia needle through the abdominal wall on the other side, as near to the linea semi-lunaris as possible. A series of these sutures were passed from below upwards, and tied as they were passed. The result of this was to make the two halves of the abdominal wall to overlap; in this case the patient was sufficiently fat to interfere with this being effected as perfectly as in some other cases that Mr. Carless mentioned. Some trouble arose from some of the stitches being carried through the rectus muscle instead of through the linea semilunaris, thereby wounding some of the veins within the muscle substance, and necessitating a troublesome search for the bleeding point. When the right flap had been effectively secured by sutures under the left, the margin of the latter flap was effectively stitched down to the outer aspect of the right linea semilunaris and sheath of the right rectus. It was then found that the skin and subcutaneous tissues were much too abundant to cover in the abdominal wall, and therefore a large flap of this, about 6 in. broad in the centre, was excised by a curved incision reaching from one end of the wound to the other. The opposite flap of skin and subcutaneous tissue was laid down in this space and secured in place by sutures. A drainage tube was inserted for 24 hours, and the wound dressed in the usual way.

Mr. Carless commented on the extremely satisfactory

results which followed operation of this character. He had performed it now a good many times, and was much pleased with it. Practically it consisted in overlapping the abdominal parietes in a manner similar to that which would transform a single-breasted to a double-breasted coat. The anterior portion of the abdominal wall has its strength thereby doubled, and the extensive removal of skin and subcutaneous tissue will assist in keeping the parts taut. Care has, of course, to be taken in the passage of the deep sutures not to wound viscera nor to allow omentum or intestine to become entangled in the threads.

It is interesting to note that this patient's wound has healed perfectly, and remained firm in spite of an acute attack of bronchitis.

### Legislation Against Street Noises.

WE have received from the Street Noise Abatement Committee a petition to the Prime Minister, urging immediate legislation respecting unnecessary and objectionable street noises, especially including noisy and dangerous motor-omnibus traffic, street shouting, and organ-grinding. It is signed by about 500 representative noblemen, members of Parliament, solicitors, merchants, hotel proprietors, etc., and by about 100 representative members of the medical profession.

### TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD WEDNESDAY, FEBRUARY 3RD, 1909.

The President, Dr. JAMES RITCHIE, in the Chair.

MR. J. M. COTTERILL opened a discussion on THE TREATMENT OF VARICOSE VEINS OF THE LOWER EXTREMITIES.

He referred shortly to the pathology of the condition, and pointed out that we were still to a large extent ignorant of the cause of varix in many cases. Still, we could divide causes into predisposing and exciting, among which he enumerated as the most frequent heart disease, pregnancy, abdominal tumours, and occupations necessitating continuous standing. In connection with treatment, the general health required attention; tonics, bathing, regulated exercise, were all in place. The actual local treatment of varix was either palliative or radical. He pointed out that when palliative treatment was once begun, it was generally necessary to carry it out for the rest of the patient's life. He thought, therefore, that when the varicose veins were small, confined to the lower leg, and giving rise to no discomfort, it was not necessary to treat them locally at all, particularly as there was in many cases a tendency towards natural improvement in later life. Palliative treatment consisted in the application of a support. He preferred a Martin's bandage, though a few patients could not tolerate it. It must be applied carefully, and both it and the leg to which it was applied must be thoroughly cleansed every time it was put on. If perspiration was troublesome he sometimes applied it over a cotton stocking, which was renewed and washed daily. Failing a Martin's bandage, an elastic stocking should be used. It was convenient, but care must be taken that it fitted properly, because, if it did not, the pressure was applied unequally. The radical treatment of varix might be divided into that of simple cases and that of cases complicated by thrombosis or phlebitis. In simple cases the degree of regurgitation of blood could be simply measured by Trendelenburg's test. The limb was held upright for three minutes to empty it of blood, and then a pad was applied to the saphenous vein in the thigh. When the patient stood erect, the pad was removed, and the rate at which the blood filled the vein was noted. The operation he advised was the ligature and removal of an inch of vein in one, two, or three places, as required. It was particularly important to maintain thorough asepsis, and to keep the patient in bed for three weeks to avoid the risk of embolus. The operation should not be undertaken without due consideration in gouty sub-When an ulcer was present, it was advisable to wait until it was healed; another contra-indication was the existence of thrombosis of the deep tibial veins. In cases complicated by thrombosis, rest in bed for a period of about three weeks or more was required. If, in spite of rest, the thrombosis seemed to be spreading up the leg, it was a question whether it was not advisable to try to hinder its spread by removing a piece of the vein above. When, however, thrombosis was due to some blood condition, as in typhoid, he questioned whether operation would be justified, as a fresh thrombosis might develop at the point of ligature. In simple phlebitis rest was all that was needed. In phlebitis leading to local suppuration and abscess formation, operation might be tried. In infective phlebitis it was advisable to try to check the process by ligature and excision of a piece of the vein. In operating high up, however, there was always the danger of dislodging a

piece of thrombus into the femoral vein.

Dr. George Hunter spoke of the importance of attending to anæmia in cases of thrombosis, mentioning as a particular instance the case of a bleeding fibroid causing varicose veins, anæmia, and thrombosis.

Mr. Downen preferred a crape bandage to an elastic one. He had in several instances been compelled to tie the saphenous vein close to the femoral, and had had no trouble with thrombus formation. He thought that thrombosis was often due to infection with

organisms of low vitality.

Mr. Scot Skirving urged the special importance of asepsis in vein operations. He had in several cases employed Mayo's subcutaneous method, but had failed with it when the vessel wall was friable.

Mr. STRUTHERS inquired as to the ultimate results of operation. In out-patient practice a great number of patients had varicose veins which gave no discomfort, and a good many were seen who had been operated on at one time or another and had relapsed. Hospital patients so quickly passed from under observation that it was not easy to say how many were permanently cured. He also asked whether, and in what way, excision of varicose veins healed varicose ulcers.

Dr. NORMAN WALKER also inquired whether radical

treatment of varicose veins really tended to cure vari-cose dermatitis and ulcer. A number of those cases came under him in the skin wards, and if he could be assured that operation would check recurrence he would urge it more strongly than heretofore

MAYO'S OPERATION. Mr. GEO. CHIENE described Mayo's operation, and showed the special instruments devised. He advocated the operation on the ground that it was more radical, and took a shorter time, than excision of parts of a Of 40 cases of varix operated on, 20 by Phelps' operation and 20 by Mayo's operation, he had traced 30, and the results were on the whole better after the former procedure.

Drs. DARLING and ARMOUR preferred crape or web-

bing to Martin's bandage.

Dr. CHALMERS WATSON asked why gout should be looked upon as a contra-indication to radical measures? Gouty persons stood operation perfectly well.

Dr. Jamieson asked in what proportion of patients

embolism actually occurred?

The President thought it was desirable to institute palliative measures, even if there were no symptoms, in order to prevent the patient's condition becoming worse as time went on. He referred to two cases of

worse as time went on. The referred to two cases of serious embolus occurring in his practice

Mr. COTTERILL, in reply, said that the form of bandage used was not of great importance, though, with the qualifications stated, he preferred Martin's bandage. He thought the operation he employed sufficiently radical, and was satisfied with the results it gave. Mayo's operation was unnecessarily severe. The ulcers which resulted from varicose veins might be due to a vicious circle, in which blood returning from the leg flowed back in the saphenous vein without being purified. He had followed up a number of being purified. cases, and in most the results were permanently beneficial. He quite agreed as to the need for treating anæmia in cases of thrombosis. With regard to the danger of embolism, he had not seen this occur from thrombosed varix. He had once seen a fatal embolism occur in an elderly man from thrombosis arising in connection with a fracture. He thought that after three weeks' rest there was little risk of embolus taking He thought that after place.

Drs. G. A. GIBSON and W. T. RITCHIE communicated an account of a

CASE OF STOKES-ADAMS' DISEASE due to partial heart-block. The main features of the case (which was of historic interest as having occurred in the person of a prominent member of the medical profession) were as follows:—The patient had enjoyed good health, and had led an active life until over 70. He was suddenly seized with an epileptiform attack rigidity and unconsciousness lasting for over an hourwith a pulse of only 6 per minute. He gradually re-covered from this, but after an interval of some months the attacks recurred. Ultimately he developed a persistently infrequent pulse (32 per minute), without any further syncopal attacks. From his own record of his case it appeared that the attacks were unaccompanied by any sensation of faintness, of angina sine dolore, or of impending death. He never had Cheyne-Stokes' respiration. His alimentary, respiratory, nervous, and urinary symptoms were normal. The heart was enlarged and the apex beat forcible. There was a shrill systolic bruit in the mitral area, propagated to

the tricuspid region; the aortic second sound was accentuated; during the ventricular pause the auricular contractions could be heard. The pulse varied between 28 and 32 per minute. The systolic blood pressure was high (230 mm. Hg.); the diastolic low (70 mm. Hg.). The jugular pulse was always of the auricular type. A number of tracings illustrating the circulatory phenomena were shown. The radial pulse tracings showed that the beats were not quite rhythmical; on the descending limb of the tracing auricular waves appeared. These, however, were better seen in the tracings from the apex beat. Comparison of the venous and radial trace showed a complete disassociation of the action of the auricles and ventricles, the carotid wave occurring at regular intervals without reference to the auricular pulse. For the sake of comparison, tracings from similar cases were thrown on the screen. One of them illustrated the action of atropine on the auricles but not on the ventricles, in heart-block. The auricles were beating at the rate of 230, the ventricles at 16 per minute. Tracings taken by means of Einthoven's string galvanometer (electrocardiograms) in cases of heart-block, lent by Professor Einthoven were also shown. Dr. Ritchie described the pathological changes which were formed, and demonstrated the lesion of the auriculo-ventricular bundle, etc., by means of lantern slides.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF ANATOMY AND PHYSIOLOGY

MEETING HELD FRIDAY, JANUARY 22ND, 1909.

The President, Dr. T. H. MILROY, in the Chair. THE PRESIDENT, having thanked the Section for the honour conferred upon him in his election to the Presidency, said he wished to put before the members the result of some work which he had done on reaction time, and which he had undertaken in order to study the nature of mental fatigue.

FATIGUE DURING REACTION TIME EXPERIMENTS.

By reaction time is meant the period which elapses between the initiation of a sensory stimulus and a volitional motor response on the part of the stimulated individual. Thus one might estimate this time for hearing, sight, or touch, taking the same type of motor response as indicator in each case. When a series of reaction times are taken for any of the above-mentioned senses, one observes that there are naturally distinct variations in the intervals between the sensory stimuli and the motor responses; but one may also observe that in all cases, after a prolonged series has been taken, fatigue gradually sets in, as shown by a lengthening of the reaction time. This fatigue might affect the sensory paths, the sensory centres, the intermediate central paths between these centres and the voluntary motor centres, or the motor path as far as the muscles themselves. The experiments were carried out in order to arrive at some knowledge as to the most probable seat of the fatigue. In all cases a preliminary series of reaction time experiments was taken in order to obtain an average normal result. Then, following such a series, various devices were employed in order to fatigue, if possible, mainly the sensory, then in another series mainly the intermediate central paths, and, in still another, the motor paths. The following may be taken as an example of the procedure adopted in connection with the analysis of the fatigue produced during reaction time for hearing experiments. At first the average normal reaction time for hearing was obtained. Then the person was asked to follow carefully the ticks of a metronome beating regularly, and to keep count of the beats. This could be done without straining attention beyond a very slight extent. After varying periods of this metronome counting the reaction time for hearing was again taken. It was found that there was practically no lengthening of the reaction time, even after the person had listened to the metronome for one hour. In another series of experiments the person was asked to count the irregular ticks produced by toothed wheels acting on one

another, the speed at which those were driven being varied. After varying periods of this form of sound production, the reaction time for hearing was again taken. It was found that, even after shorter periods than in the case of the metronome, slight fatigue was produced as shown by the lengthening of the reaction time. In still another series the reaction time for hearing experiments itself was used throughout to produce the fatigue, and it was found that the lengthening of the reaction time took place much more rapidly than was the case in the immediately preceding series. principal difference in the nature of the three series was the degree of attention which was required to be directed towards the act. This was least in the first series and greatest in the last. It was then deemed advisable to study the effects of interpolating between two series of reaction times for hearing, a series of similar ones for sight, or between two series of sight reactions, one for hearing. In practically all cases a change of this character did not prevent or even delay the usual onset of fatigue. In fact, if there was more variation than the above-mentioned in the reaction times series—as, for example, hearing, sight hearing, sight—the lengthening in the last series of reaction times for sight was greater than it would probably have been had reaction times for sight been taken throughout the whole experiment. In these experiments the sensory paths were varied, the central in part varied, while the motor path remained the same. Although the central path was varied in so far as a transmission had to take place from a different sensory centre to the same motor one, there was one central system common to all—namely, that concerned in directing attention to the translation from the sense perception to the volitional act. Therefore, as the sensory channels have been changed, and the path from sensory centre to voluntary motor centre also varied, if these changes mean rest to the unemployed paths, then fatigue must have affected either the higher neurone systems concerned in the maintenance of what we term "attention," or the neurones concerned in the transmission of the motor impulses. That it is not the latter is shown by the results of certain experiments which were carried out with the view of fatiguing, if possible, the motor path without affecting to any marked extent the higher centres concerned in the maintenance of attention. This was done by asking the person to carry out similar motor acts to those employed in the ordinary reaction time experiments. No sign of fatigue was to be observed, as judged by the average duration of reaction time, before and after such a period of motor activity. An example of the degrees of fatigue produced by changing from one form of reaction time to another (the motor response in each case being the same) may be given—(1) Normal reaction time for sight, .206 seconds (average over twenty-five minutes; experiment 250 observations). (2) Subsequent reaction time for hearing, .225 seconds taken for ten minutes (the normal for hearing being below .200 seconds). (3) Continuation of (2) for another ten minutes, reaction time (hearing) .267 seconds. (4) Reaction time for sight taken in conclusion for a period of ten minutes, .271 seconds. This degree of fatigue from .206 seconds to .271 seconds is probably not less than would have occurred had reaction times for sight been taken throughout the whole experiment. From a careful study of a large number of experiments on the reaction time, it appears as if in all cases the fatigue has its seat in the higher centres concerned in the direction of the attention towards the sensory motor reaction. These higher centres appear to be required in order to link the These higher various synapses of the higher psychical and volitional motor centres more closely together, and thus facilitate the transmission of the nervous impulses. in their fatigue there is a delay in transmission probably due to the higher resistance at the synapses, which are not so closely linked together as when the attention is freshly directed towards the act at the outset of the

Professor Dixon expressed the thanks of the Section to the President for throwing so clear a light on the action between neurones; his method of tackling the

problem was undoubtedly the right one.

Professor Fraser said there was a great difference between the effect of a bell sounding for dinner and a burglar alarm at night, although the path was the same.

Dr. Dawson said that if the President's theory was correct it would appear that the site of the evil, so far as it had a local habitation, must be somewhat

higher than the faculty of attention.

Dr. WALTER SMITH said that the fundamental value of the communication appeared to be its introduction of quantitative measurements into the estimation of psychological and sensual processes. In judging of reaction time, an important factor was the duration of the stimulus. There was a great difference between the momentary impact of a visual stimulus and the relatively long duration of even the shortest sound. The subject was valuable to physicians and surgeons in estimating the phenomenon of knee-jerk, or the many manifestations of disordered and delayed sensations in hysteria. A most important point was the fatigue in the synapses between neurones. It was possible to draw an analogy between mental and digestive processes: in the nervous system they might recognise the possibility of a stimulus of stimili just as there was in the digestive system a ferment of ferment.

Dr. MOORHEAD said he strongly believed that after a short rest following work one could turn to a new variety of work that required just as much attention, whereas if one turned to the same kind of work the same power of attention would not be appreciated.

The PRESIDENT, in reply, said the nature of impressions varied according to the stimulus. One's idea of certain sounds was based on past sensations and memories which called forth a different mental condi-There were certainly two paths between neural centres, one voluntary, the other formed by habit, but they could not say whether the linkage was always made by the one path, nor could they recognise where volition came in. His tests were for the purpose of finding where fatigue occurred, not to find what alterations in duration of stimuli produced—that had been carefully worked out by others. It was difficult to tell how change gave rest. Sight plus hearing would produce greater fatigue than one form of fatigue carried the whole way down.

### NOTES ON THE STERNO-CLAVICULAR JOINT.

Dr. H. M. Johnston gave a communication on the above joint, and exhibited drawings in illustration of the interesting points brought forward regarding the anatomy of the articulation and the movements of the The security of the joint was shown to depend mainly upon the costo-clavicular ligament, which penu mainty upon the costo-clavicular figament, which is always tense, even when the upper extremity is hanging by the side. Owing to the attachment of this ligament to the clavicle being on the posterior-inferior aspect, elevation of the clavicle is permitted by a movement of rotation taking place, during which the anterior surface of the bone becomes directed somewhat anterior surface of the bone becomes directed somewhat upwards. The interarticular meniscus, intervening between the inner end of the clavicle and the sternum and first costal cartilage, and against which, owing to the laxity of the capsular ligament, the articular surface of the clavicle can move (upwards and downwards, forwards and backwards) serves rather as a "buffer," preventing shocks and jars being transmitted to the sternum, than as a ligament. To the sternum and costal cartilage (this meniscus intervening) the inner end of the clavicle seems to be, as a general rule, firmly applied. During pulling, and when supporting the weight of the body by hanging from the hands, the clavicle is drawn somewhat outwards. occur during reaching movements, as the contraction of the subclavius muscle prevents the clavicle being drawn away from the sternum as the scapula moves This fact can be readily outwards and forwards. demonstrated in the living subject.

Professor Dixon stated that he had seen the dissections of the joint made by Dr. Johnston, and was convinced that the explanations given of the function

of the costo-clavicular ligament and of the subclavius muscle were the correct ones.

Professor FRASER, Dr. MOORHEAD, and the SECRETARY expressed their appreciation of the work done, and of the interesting nature of the conclusions submitted by Dr. Johnston.

In replying, Dr. Johnston called attention to the fact that the nerve-supply of the subclavius muscle was from the same source (5 and 6 C, as the upper part of the serratus magnus, which muscle was so intimately associated with the reaching forward movements.

#### DORSAL SUBCLAVIAN ARTERY.

Professor M'Loughlin exhibited a specimen of the above. There were three branches from the arch of the aorta. The first branch was a stout trunk, 6 mm long and 22 mm. wide, which gave off the two common carotid arteries: the second branch, which lay against the first, was the left subclavian, and the third branch, 12 mm. behind the second, was the irregular right subclavian.

DUODENAL DIVERTICULUM.

Professor M'Loughlin next exhibited a specimen of duodenal diverticulum. The opening was oval (16 mm. by 13 mm.), and was situated between the bile papilla and the caruncula minor, the centre of the opening being 10 mm. above and to the left of the former, and 12.5 mm. below and to the right of the latter. The hood-like valvula connivers above the bile papilla passed down the right wall of the diverticulum. The upper boundary of the opening was sharply defined by a curving valvula connivens, the sac passing up underneath this overhanging edge. The lower and left walls of the sac sloped gradually on to the somewhar smooth mucous membrane of the duodenum below. The depth of the diverticulum was 18 mm. On being dissected from the back, the diverticulum was found to be embedded in the head of the pancreas, and supported behind in its right half by the bile duct. The duct of Wirsung coming down through the head of the pancreas swept to the right round the lower part of the diverticulum, and there joined the bile duct about 12 mm. from the opening on the bile papilla. The duct of Santorini passed up from the lower part of the head in front of the duct of Wirsung, with which it com-municated by a large branch, and then curved round the left side of the sac, rising as it passed forwards to open into the duodenum above and to the left of the diverticular opening. An artery from the gastro-duo-denal artery dropped down to the wall of the sac and was distributed in several branches. In commenting on the absence of any satisfactory explanation of these diverticula, which are usually found in the situation described, the exhibitor suggested that in these diver-ticula we possibly had evidence of an effort of the duodenum to produce a gland—perhaps part of the pancreas, perhaps a gland that was neither pancreas

Professor Dixon and the President briefly discussed the communication, and, in reply to Dr. H. M. Johnston, Professor M'Loughlin stated that the wall of the sac was thin and composed chiefly of mucous membrane, but a ring of muscle was present around the circumference for a short distance up the wall.

LANTERN DEMONSTRATIONS OF SURFACE ANATOMY.

Professor Fraser gave a lantern demonstration of a series of slides, showing (a) the living model from the front, the back, and the side, with the superior extremity in various positions; ((b) a series of the head and neck, showing the various movements, flexion, extension, lateral inclination, and rotation to right and left; (c) a series of the trunk, showing its various movements—flexion, extension, lateral inclination, and rotation to right and left; (d) a series of the lower extremity, showing the various degrees of flexion from the outer and inner aspects of the limb.

The President and members expressed their appreciation of the beautiful series of photographs exhibited on

the screen.

THE LORD PRESIDENT OF THE COUNCIL has been pleased to appoint the Hon. Mrs. Charles Egerton to be a member of the Central Midwives Board in the place of Miss Jane Wilson, resigned.

GLASGOW EASTERN MEDICAL SOCIETY.

MEETING HELD FEBRUARY 3RD, 1909.

The President, Dr. J. W. MATHIE, in the Chair.

### CEREBRO-SPINAL MENINGITIS.

THE President, Dr. MATHIE, read notes of two interesting cases of cerebro-spinal meningitis, one that of a girl, the other of a woman, both of whom recovered. In the case of the girl, hearing was lost. An interesting discussion followed.

interesting discussion followed.

Dr. Granger stated he had attended 17 cases, with several recoveries. He had found deafness the most

common complication.

Dr. GLEN had had a case followed by hydrocephalus. Dr. MACLACHLAN said that cerebro-spinal meningitis was a disease very difficult to diagnose in the early stage, as it was apt to be mistaken for influenza or pneumonia. The severe headache and general malaise did not yield to salicylate of soda, as was generally the case with influenza attended by headache and myalgic pains. He had employed aconite successfully in two cases where the symptoms pointed to cerebrospinal meningitis. Two cases where a more or less expectant treatment had been adopted died within four days. Although aconite was not classified as an antiseptic, he had no doubt as to its power, when used early and vigorously, in diseases that undoubtedly were connected with germ life.

Dr. Peter Buchanan showed a woman whose fore-

Dr. Peter Buchanan showed a woman whose forearms were short and flail-like. At the right elbow-joint there was a considerable gap between the humerus and the bones of the forearm, while on the left arm the radius and ulna met the humerus obliquely one or two inches above the normal site. The inner condyles of the humeri appeared to be absent.

Dr. McKall showed a woman, æt. 63, with a rodent ulcer on the upper eyelid of the left eye. It was of two years 'standing. It was depressed in the centre, and had a hard-rolled edge. There was no pain; but it bled when the face was washed. It was about the size of a shilling.

### A CASE FOR DIAGNOSIS.

Dr. James Dunlop brought a man with an affection of the tongue for diagnosis. He was æt. 40, and had a somewhat clay-coloured complexion. There was a large, ragged, dirty-looking ulcer, foul smelling, on the dorsum of the tongue. It was very painful. It had begun as a small lump rather to the right of the middle line of the tongue, which the patient declared had broke two months ago. He had syphilis many years ago. There were a mass of glands under the sterno-cleido mastoid on either side of the neck, rather low down. The prevailing opinion was that it was syphilitic in origin; that a course of iodide of potash should be given. There was a large white patch of leuco-plakia on the tongue, and one or two speakers considered it was malignant in nature.

CLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD IN THE FACULTY HALL, JAN. 22ND, 1909.

Dr. WALKER DOWNIE in the Chair.

Dr. Robert Muir, Professor of Pathology in the University of Glasgow, read a paper the subject of which was "A Consideration of Some of the More Recent Work on Immunity, especially in Relation to Diagnosis and Treatment."

A short discussion followed, and Dr. LINDSAY. STEVEN proposed a vote of thanks to Professor Muir for the interesting paper he had read before the Society, an abstract report of which will be found in another column, under the heading of "Original Papers."

By permission of the Lord Mayor of London, the annual meeting of the Royal Free Hospital will be held at the Mansion House on March roth next at 3 p.m., when the claims of the hospital for increased public support will be advocated.

# CORRESPONDENCE.

# PROM OUR SPECIAL CORRESPONDENTS ABROAD.

# FRANCE,

Paris, Peb. 7th, 1909.

THE SEMEIOLOGY OF PAIN.

PAIN, in a medical and philosophical point of view, is an interesting phenomenon, any definition of which would be useless as it is personally known to all; in any case, it is an experience that no one cares to recall.

Yet it is, says Dr. Legendre, one of the best agents of human progress; it is a useful phenomenon; it denounces conditions that might be hurtful and puts the

individual on his guard.

It is impossible to separate physical pain from moral pain. When an individual suffers from dental neuralgia, for instance, he not only experiences physical pain, but also a degree of impatience which, if prolonged, produces nervous prostration, rendering incapable of work or thought. If the affection is incurable, as sometimes happens, the mental condition becomes such as to lead the patient to the verge of suicide. On the other hand, moral suffering, as some acute disappointment, the loss of a loved one, produces physical sensations, general malaise, epigastric oppression, loss of appetite, insomnia, neurasthenia.

Acute pain lowers the temperature, and slight pain accelerates the beating of the heart, while excruciating pain produces syncope. Arterial tension is generally lowered if the pain is intense and prolonged, and the iris is dilated. The number of respiratory movements increases if the pain is moderate, if it is intense the respiration is slow, with a pause during the inspiration and expiration; where the expiration is prolonged, a groan is heard which is nothing else than a pro-longed expiration with contraction of the glottis.

In pain, the secretion of the gastic juice is suppressed, with loss of appetite and great thirst, explained by perspiration (cold sweats). Diarrhœa is frequently observed, and tears are the first results of acute pain in children and those who are of weak will

Pain differs in intensity, not only in different categories of individuals, but also at different periods of human life. The infant, for instance, would seem to suffer the least of all, in any case, the lachrymal secretion is not observed for several weeks after birth. In children, the most intelligent are the most sensitive, and girls more so than boys. Sensibility increases up to the age of 25, and then decreases gradually to old age. Aged people, as a fact, suffer much less than adults; hepatic colic, for instance, so painful in middle life, passes almost unnoticed in persons of advanced years; the pain is dull, vague and attenuated, so that error in diagnosis is frequent, and when jaundice sets in, the case is supposed to be one of cancer of the pancreas. Pneumonia in the adult sets in by violent pain in the side; in the aged, it begins insiduously. Woman seems more sensitive to pain than man, but she endures it better.

Professions exercise also an influence on the character of pain; persons of liberal professions suffer more acutely than workmen.

The races are also remarkable in this respect. Orientals, Egyptians, Arabs, Chinese, Japanese resist pain much better than Europeans.

Does pain result from excessive irritation of sensitive and sensorial nerves? Such was the conviction hitherto, but to-day there is a tendency to admit the existence of centres of pain and that of special nerves.

Pain produces pain; consequently, patients should be examined with gentleness, so as to cause the least suffering possible to the patient, and not to be hindered in the examination. The physician who increases the suffering of his patient places himself in an unfavourable position to make a good diagnosis.

It should be borne in mind, also, that inflamed tissues are particularly painful, and that tissues normally without much sensibility, as tendons, cartilages, periosteum, fibrous tissue, and such organs as the in-

testine, bladder, uterus, become very painful under the slightest congestive conditions; in certain affections-

phenomena occupy the foreground.

Certain pains return at a fixed hour, while others are particularly nocturnal. Night increases pain, perhaps chiefly in a moral point of view. During the day he mind of the patient is more or less diverted from his suffering; at night he is left alone with his thoughts.

Pain can be either persistent (migraine) or mittent (hepatic, nephritic, or intestinal colic). In inflamed tissues (phlegmon) the pain is pulsatile; other types of pain are lancinating, fulgurating (ataxy), terebrant (cancer of bone), burning (erysipelas).

Some pains are purely suggestive, and correspond with no precise morbid condition, while others are experienced at a distance from the affected region. In pericarditis, for instance, the pain felt in the epigastrium and between the insertions of the sterno-mastoid muscle, is characteristic. Pain in the right shoulder in disease of the liver, in the ear in tonsillitis, is well known. In consumptive persons, besides intercostal neuralgia, pain is frequently felt in the shoulder, the neck, wrist and fingers. Certain affections of the uterus provoke pain in the lumbar, abdominal, and inguinal regions; dysmenorrhæa is frequently accompanied with headache, disease of the bladder by pain in the glans, while the pain in the knee of coxalgia is known to all.

GASTRIC AND INTESTINAL HEMORRHAGE.

Gelatin, 5 dr. Water, 6 oz.

Boil six hours, so that the gelatin will remain liquid. and add :-

> Citric acid, 20 gr. Syrup of orange, 5 dr.

A tablespoonful every 2 hours.

GERMANY.

Berlin, Feb. 7th, 1909 At the Medical Society, Hr. Dührssen gave a demonstration of a new method of delivery, which consisted in the following —A metreurynteur is first introduced for the purpose of softening the parts. After this has been effected a vaginal Cæsarean section is made, and, following this again, the child is extracted through a lateral suprapubic incision. The procedure, complicated as it appears, is not so, but is simple, is free from danger, and allows of a really extra-peritoneal Cæsarean section. The speaker had employed it in one case, with the result that a living child was born, although the same woman had lost her two previous children inter partum. The patient made a good and easy recovery.

Hr. Solms had thought of the method, and had carried it out in one case, and recommended its employ-

ment in suitable cases.

Hr. Krömer objected to it as too complicated, and for that reason too dangerous. In place of it he recommended the procedure as carried out in Bumm's Klinik, which was to wait until the soft parts were dilated (the metreurynteur might be used for this if necessary), and then the extra-peritoneal Cæsarean section was performed, if required; otherwise hebosteotomy was done.

Hr. Dührssen, in reply, defended his own method, which he proposed to call "laparo-colpo-hysterotomy."

The Deutsche Med. Zeitung, 6/09, gives a brief account of a paper by Reg. U. Med. Rat Dr. Nesemann, of Berlin, on

THE HISTORY OF TYPHOID FEVER IN BERLIN.

The article deals with the history and the ætiology of the disease, and presents a striking picture of the evils of insanitary conditions and of the startling improvement that follows on practical attention to health requirements. The mortality statistics for the different years show, on the whole, a gradual decline. On two separate occasions a rapid fall took place—namely, in the years 1878 and 1894, on the first occasion from 612 in the previous year to 326, on the second from 143 to 67. The explanation of this lay in the sanitary work to 67. The explanation of this lay in the sanitary work that had been carried out in limiting or completely shutting off of river water, and replacing it with deep well water (Tegeler Werk).

writer's conclusions are as follows:-"The general high morbidity and mortality from typhoid fell at a time when the greatest insalubrity reigned, the soil and all the water-courses were fouled, the wells were a prey to all sorts of uncleanness, the central water supply not of the best, fæcal matter was but imperfectly removed, and in part was positively dangerous as regarded health. With the gradual improvement of these conditions, a gradual decrease of typhoid took place; the diminution was first noticeable in the streets that were sewered, probably for the reason that the soil became less saturated, and the water of the wells less contaminated.

A great and sudden fall both in morbidity and mortality was associated with a partial disuse of the highly objectionable river water, and again on its use being

given up altogether.

"For the preponderating dependence of the frequency of typhoid in a city on its water supply as compared with other factors, and especially its sewerage, the behaviour of the disease in Berlin affords a striking and instructive example."

ANTE-PARTUM BAPTISM. A paper by Dr. Treitner in the Theolog. Pract. Quartalschrift discusses this subject. The writer says that hitherto an attempt has been made to baptise the living fœtus in utero by means of the finger or with a syringe introduced into the uterine cavity. The objection to the first-named method is that the water is soon wiped off the finger as it is passed through the vagina, and before it reaches the fœtus at all; by the second method the membranes must be perforated. Then the syringe must be guided by the finger in order that the baptismal water may reach the child's head. There are

difficulties in the way of this when the os uteri is small,

and in the earlier months of pregnancy.

The writer, a practitioner of Innsbruck, therefore proposes the following method of procedure: A syringe is filled with the baptismal water; the syringe should not be disinfected with any disinfecting fluid, as some of this may get mixed with the baptismal water, whereby the latter would lose its efficacy. In case of a head presentation, the puncture is made above the symphysis, the syringe is passed in until it touches the head of the child. If nothing like the head is felt the instrument is withdrawn as far as the abdominal parietes, and a trial is made in another direction; the operator will not have to make more than three or four tries. If the mother is dying, so that she cannot be uncovered, the puncture must be made through the dress. In any case the puncture must be made with force, and the operator need not be afraid of penetrating the child's skull; it will do the child no harm; it is important, as the child's head may be covered with "Kindspech," and for this reason the baptismal water might run away from the child's head. (The con-tributor who is responsible for the insertion of this paragraph feels himself bound to add that it is not a sorry jest.)

# AUSTRIA. Vienna, Feb. 7th, 1909.

OUR PRESENT KNOWLEDGE OF CHOLERA.

AT the Gesellschaft, Kraus reviewed the present treatment and diagnosis of cholera, which, he thought, should be in the minds of every practitioner when the disease was so near. The recent cholera epidemic in Russia had given him many opportunities of testing the worth of many of the prescribed methods, but it is yet certain to the most casual observer that more must be learned of the cause before we can dogmatise on the treatment. It is still a difficult task to diagnose the vibriones, although it is confidently affirmed that hæmotoxin is diagnostic, but Kraus now assures us this is not the case, as we have invariably to fall back on Pfeiffer's biological test to distinguish the true cholera vibrio. Even this test does not distinguish the El Tor vibrio of the Arabians from the genuine Asiatic vibrio, which has been confirmed by Gottschlich, who examined the vibrio taken from the bowel of deceased Mecca pilgrims who did not die from cholera, but when it was cultivated and injected had all the characteristics. In this case the biological test is quite falla-

Notwithstanding these facts, we have high authority for believing that these vibriones have a choleraic nature and may transmit genuine cholera to a third party. Kraus next referred to his own experiments with the El Tor vibrio, which he cultivated and obtained the biological result and all the characteristics of cholera, even to the formation of hæmotoxins, and yet the cholera symptoms were not present. From this he concludes that the biological method is not reliable, as the El Tor vibrio can be cultivated for months, and even years, with the same constant result. Again, he gave a history of 23 cholera cases which he examined in the 1907 epidemic in Russia, where the vibrio produced no hamotoxin, which, according to the latest theory, would be regular. He concluded that the theory, would be regular. formation of hæmotoxin was not reliable, but was in favour of the "Blut Platten" method being the sovereign diagnostic sign of the disease. Where an epidemic was present the agglutination method would be handy and reliable in general practice.

We have now to consider an anti-toxin, but from

the number of the vibriones that so closely resemble the cholera germ we are at a loss to select a specific that will neutralise the genuine cholera toxin. vestigators have affirmed their successful treatment with a product of their own. As to whether these have any prophylactic or healing powers great doubt is enter-tained, but it is reasonable to believe that such exists, as injections of serum in mice and guinea-pigs have shown that the cholera vibrio can be resisted for a long time, if not altogether neutralised. The experiments at present give very little hope for success with any serum, although guinea-pigs have been found to remain immune for a long time. The tests in vitro give no more satisfaction than the biological.

In the recent Russian epidemic Kraus has used an anti-toxic serum which he obtained from the El Tor vibrio. He has injected 119 cases, in 70 per cent. were subcutaneous, and injections in 49 intravenous. Of the subcutaneous cases, 58 per cent. died, while the intravenous had a death-rate of 50.6 per cent., which may be compared with the total death-rate of untreated cases, which is 58.7 per cent. This makes very little difference from a statistical point of view, but when we consider that the doubtful or hopeless cases were only injected, the mortality shows a favourable reduction by the serum treatment. Early injection is another factor to be considered, as we know the antitoxin in diphtheria, when delayed three or four days, makes the results very doubtful. Hence early treatment, more particularly in cholera, must be recognised, and the best form intravenous with a solution of salt as the vehicle. Zeatogorow in 1904 vaccinated in North Persia with a serum whose results showed that the mortality was four times less in the vaccinated than in the non-vaccinated, while the attacks were five times less. Other authors in the same region give similar results.

# HUNGARY. Budapest, Feb. 7th, 1909.

HOSPITAL ABUSES IN BUDAPEST.

HOSPITAL abuse occurs in Budapest as in other large medical centres. The leading medical charities in Budapest are the Royal Policlinic, and the "Out-Patient Departments" of all the Clinics. Patients applying for advice or treatment at those institutions are asked to give their names, ages, occupations, and addresses, no further guarantee of fitness for receiving help from a charitable institution is required. Budapest, as in other large cities a large proportion of those benefiting are quite above the class that were originally intended to be beneficiaries. While the medical officers are fully conscious of the existing abuses, the general feeling amongst them is that it is not their part to take any action. It is, indeed, very questionable if it is in their power to do anything to improve matters, for questions as to wage earnings, etc., too often only elicit evasive or erroneous answers, and only trespass still further on the medical officers' time. Another way in which medical men in Budapest are exploited is by the numerous and, in some

cases, very large Friendly Clubs and Sick Clubs, so numerous and large indeed that their members compose a very considerable part of the community. These friendly clubs, etc., pay their medical men annually 4s. 2d. per member, 5s. if, in addition, the family of the said member is attended.

THE HEALTH OF SCHOOL CHILDREN,
The annual report of the Medical Officers of the
Budapest Municipal Schools states that a large number of the children suffered from general debility, scrofuof the children suffered from general debility, scrofulosis, and tuberculosis. Of 11,379 children for whom admission was sought, 334 had to be refused for general debility, 138 for scrofulosis, and 67 for tuberculosis of the lungs; at the same time 317 children suffering from general debility, 3 suffering from scrofulosis, 90 suffering from pulmonary tuberculosis were admitted which to their kept under medical cheeryties. subject to their being kept under medical observation. Of all the 91,384 children attending the municipal schools 1,347 suffered from imperfect nutrition, 519 from scrofulosis, and 417 from pulmonary tuberculosis; all these case were, accordingly, kept under medical observation. The report draws the attention of the school authorities to the great number of chil-dren who are insufficiently fed and suggests that this question might form the subject of a collective investi-The municipal authorities support milk and bread distributing institutions in every district of the

POTT'S DISEASE IN CHILDREN.

From an extensive study of the disease, as well as considerable experience in dealing with same, Dr. Alapy draws the following conclusions:—(1) Tuberculous spondylitis is pre-eminently a disease of the young child. (2) The greatest number of cases is found between the ages of 2 and 8 years. (3) In his hospital experience the author met a greater number of girls than of boys, the number of the former being almost double that of the latter. (4) The duration of the disease before the admission to the hospital was between a few weeks and one year. (5) In the presence of undoubted predisposition, whether because of heredity or on account of surrounding conditions of life, measles and at times trauma may serve as the startingpoint of the disease. The complication of spondylitis by measles shows itself very rapidly in deterioration of the patient's condition. (6) The lumps were mostly found in the thoracic portion of the spine; the lower thoracic vertebræ were usually the most affected, and the curvature was generally limited either to these vertebræ or to the upper lumbar. (7) With the evacuation of the abscesses, followed by filling up of the cavities with a 10 per cent. solution of iodoform emulsion, or after a curettage done with the same aim in view, followed by a hermetic closure of the opened abscess, satisfactory improvement would be observed in those localities where the skin has not grown too thin. (8) Cases of active surgical interference and further treatment with drainage also showed a considerable degree of improvement, though the most frequent post-operative complication was usually a febrile condition. (9) Correct methodical extension and counter-extension in bed often, in combination with suspension with the Sayre apparatus, are to be considered as the best means in the majority of cases of checking the development of the tuberculous process, and of creating favourable conditions for the further treatment with corsets. (10) Besides the specific treatment, it is absolutely necessary that resort be had to favourable climatic surroundings, as in special sanatoria at the sea shore or on the mountains, but never in hospital. (11) Out of six who died, four were found to have suffered from pulmonary tuberculosis, and two had, in addition, fatty degeneration of the heart.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

# SCOTLAND.

ABERDEEN ROYAL INFIRMARY.-The directors of the Aberdeen Infirmary propose to enlarge the institution by erecting three new operating theatres, with the usual annexes, by rebuilding the out-patient

department, by reconstructing the basement of the surgical block and adapting the space for electrical work. They also intend to improve the premises occupied by the gynæcological and ophthalmic departments, and to provide better rooms for the resident medical and nursing staffs. A number of other minor alterations are contemplated, and the effect of the whole will be greatly to improve the Infirmary and extend its power for good. The expense which the changes will involve is defrayed by the generous gift of £26,758 received last May from Lord Mount-Stephen.

EDINBURGH UNIVERSITY.—Professor Chiene has been granted leave of absence for three months on account of ill-health. Mr. David Wallace, C.M.G., acts as his substitute in the course of Systematic Lectures, and Mr. Alexis Thomson has been appointed to the charge of the wards in the Royal Infirmary during his absence. Prof. F. M. Caird was entertained as the guest of the Cap and Gown Club on January 30th, on his elevation to the Chair of Clinical Surgery. The Cap and Gown Club is a very popular social club in Edinburgh, and

Mr. Caird is one of its oldest members.

THE LATE DR. ARGYLL ROBERTSON.—According to newspaper reports which have arrived from India, the body of the late Dr. Argyll Robertson was cremated in accordance with his expressed desire. The ceremony was deeply impressive. The funeral service was read by the Rev. G. S. Stevenson, and the pyre on the banks of the River Gondli was lit by the Makore Sahib of Gondal, himself a medical man, an Edinburgh graduate, and a Fellow of the Royal College of Physicians of Edinburgh. In performing this last tribute of respect to the dead, the Makore Sahib broke through the ancient customs of his race, for it is contrary to all usage for a Hindu Rajah to take part in a funeral procession, or to wear a white or black turban as mourning. Hindus and Mussulmans united in closing their shops out of respect to the deceased, and sent a message of condolence to Mrs. Robertson.

FIRE AT THE GLASGOW ROYAL INFIRMARY.—Considerable alarm was caused at the Royal Infirmary on Saturday night by a fire which broke out in the dome. The fire brigade were soon on the spot, and succeeded in getting the outbreak under control. Owing to large quantities of water descending from the dome into the ward beneath, 40 patients were removed to another part of the building. There was great excitement outside the building, but inside everything was quiet and orderly. Damage to the extent of about £1,000 was done. The dome in which the outbreak occurred was over the original building.

#### BELFAST

Women's Health Association.—The first annual meeting of the Lurgan Branch of this Association was held last week, and was most cordially supported by the local medical men. Among those who took part were Drs. Deeny, Darling, Bracken, Agnew, Pedlow, and Mrs. Haire, M.B. The committee reported that attention had been given to the subject of cookery teaching, and few medical men will find fault with their statement that both national health and temperance will be promoted by instruction in cookery and domestic hygiene. Arrangements have been made for a course of lectures on hygiene and the care of infants and school children, to be given by Dr. Marion Andrews, of Belfast. After the business part of the meeting, Professor Symmers delivered a most interesting lecture on " Some Modern Views as to the Cause of Disease."

METHYLATED SPIRIT IN LINIMENT .- An interesting case was heard at Bailieborough (Co. Cavan) Quarter Sessions before his Honour Judge Drummond. local chemist had been summoned for using methylated spirit in the preparation of iodine liniment, instead of pure, duty-paid spirit. The magistrates had dismissed the case, and the Inland Revenue authorities appealed. It was said that the methlyated spirit cost 2s. 6d. per gallon, and the pure spirit would have cost 25s. to 3os. per gallon. It was submitted that there was no case against the defendant. The liniment was in constant use as a cattle rub, and was never intended or prepared for human or internal use. His Honour said: "I consider this a scandalous case. It should not be decided here. This defendant uses a condemned drug because he can make a huge profit out of it, and the public are to be poisoned and cheated for his profit. The case should not be decided here. It is of too great public importance. I will state a case for the Superior Court if Mr. Cochrane asks me. I regard the case as one of the greatest importance."

Down District Lunatic Asylum.—Sir G. P. O'Farrell, who inspected this asylum lately, calls special attention in his report to the way in which clinical notes and histories of all cases are being kept by Dr. Nolan and his assistants. All the 751 cases on the register are kept in two volumes, one for males and one for females, by a new system, the "Kalamazoo." The printed headings of the new case records have been drawn up by Dr. Nolan on the lines of modern scientific requirements, and the assistant medical officers deserve praise, says the inspector, for the careful manner in which these records are kept.

# LETTERS TO THE EDITOR.

ONE MORE CAUSE OF THE SPREAD OF TUBER-CULOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—The sensible letter by Dr. Hodgson in your last issue has much to commend it. The ordinary feather pillow (more especially in hot weather) is execrable; one side of head roasted, the other exposed to any current of air circulating in sleeping apartment. The emanation from warm feathers is not healthy, to say the least; many prefer a horsehair pillow for this reason. I see that a hygienic pillow is now on the market, made by Messrs. Bailey and Son, Rathbone Place, which admits a free current of air under the head of the sleeper, and this should get over a good many of the objections urged against the usual form of pillow. I can imagine one of the reasons for insomnia so common nowadays is too much heat to the head, and this would also account for the change of position during sleeping hours, very few when waking finding the head in the position chosen when waiting for "Nature's sweet restorer."

I am, Sir, yours truly,
ALEXANDER DUKE.

London, W., February 5th.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is being gradually but surely brought to my understanding that the "peace of mind" I had fondly hoped for in my declining years, will not outlive many days with the rapid march of science, which even many of my poorer patients know more about than some of us who boast of University honours. In the midst of my reverie as to whether I ought not to renounce fish, flesh and fowl and become a vegetarian as the summum bonum of mundane existence, I was startled with the recently discovered knowledge that even those apparently innocent products of Nature's womb—vegetables and fruits—often swarm with microbes, and that if I dare to pick a rose in my back garden, I run the risk of septic infection from the prick of a thorn.

A week ago your contemporary the Lancet had a serious article on the sorrows attending golf, a game I indulge in, when I can get away from a strenuous practice; and later still, I am warned in my favourite journal (MEDICAL PRESS AND CIRCULAR, Feb. 3rd) by my friend Dr. Hodgson that it is dangerous to lay my head on an unsterilised pillow, lest I inhale "the swarms of germs" breathed into that same pillow by the previous occupant of the bed. It is plain, on the authority of the Lancet, that I must give up golf, although I had stupidly imagined I felt better for the game. But what am I to do with my pillow? At home this will be all right, as I can lock it up with the silver in the safe when leaving; the difficulty will arise when sleeping at the house of a friend, or at an hote!. To the managers of the latter, I would suggest

a notice in the bedrooms, "Pillows baked every morning." Such caravanseric I will patronise in due time when the practice has been perfected. Till then I shall stay at home and stick to my one pillow.

I am, Sir, yours truly,
February 5th, 1909. MUCH WORRIED.

THE OFFICIAL MEDICAL REGISTER—IMPORTANT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—A very searching inquiry is now being made as to the accuracy of all names and addresses on the Medical Register under the following Section (XIV.) of the Medical Act, 1858:—

XIV. It shall be the duty of the Registrars to keep their respective Registers correct in accordance with the provisions of this Act, and the Orders and Regulations of the General Council, and to erase the Names of all registered Persons who shall have died, and shall from time to time make the necessary alterations in the addresses or qualifications of the persons registered under this Act; and to enable the respective Registrars duly to fulfil the duties imposed upon them, it shall be lawful for the Registrar to write a letter to any registered person, addressed to him according to his address on the Register, to inquire whether he has ceased to practise, or has changed his residence, and if no answer shall be returned to such letter within the period of six months from the sending of the letter, it shall be lawful to erase the name of such person from the Register; provided always that the same may be restored by direction of the General Council should the; think fit to make an order to that effect.

On February 1st a circular of inquiry was posted to every registered practitioner, excepting only officers of the Navy, Army, and Indian Medical Services whose names appear in the Navy and Army Lists.

It is of vital importance to all registered practitioners who have not received an inquiry in course of post that they should immediately communicate with this office, as, in the event of no communication being received from them, it will be lawful to erase their names from the Register, according to the Act, and then very serious disabilities will be incurred.

I am, Sir, yours truly,
H. E. ALLEN, Registrar.
General Council of Medical Education and
Registration.

299, Oxford Street, London, W., Feb. 3rd, 1909.

#### MEDICAL MEN IN PARLIAMENT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—You draw attention in your last issue to a grave disability under which we, as medical men, suffer, in not being properly represented in Parliament. Year after year legislation is introduced placing additional burdens on our shoulders, burdens we are expected to bear cheerfully for the good of the State, without any other reward for the work. We never hear of such demands being made from solicitors or barristers, for the simple reason that personally they are well represented in Parliament, and that outside Parliament their interests are properly protected by the Law Society and the various Inns of Court. We, however, are almost without a voice in Parliament, and our corporations and associations are ineffectual or careless.

While recognising that the good offices of the medical men in Parliament are for the most part at the service of their fellows, it is important to remember that unless elected as university members, they have no responsibility to the profession. Moreover, they may not be fitted to speak with authority for the profession, their eminence being rather political than professional. If these men chance to be anti-vaccinationist, anti-vivisectionist, or cranky in other particulars regarding science or health, their position as members

of Parliament makes their opinions a hundredfold more dangerous. They are regarded, in fact, as voicing the opinion of a section at least of the profession, while merely uttering their own cranky notions. The presence of such people in Parliament is a danger, and medical men would be better without them. On the other hand, medical men who are eminent as politicians are not unlikely to be nonentities in a professional respect, and their utterances on medical subjects tend to make us ridiculous. Unless, therefore, we can be represented by the right sort of men, I believe we are better without medical men at all in the House. Under present conditions, the Universities seem to be the only constituencies which can return suitable medical members, and medical electors should do their best to find and support suitable candidates for the Universities. In the failure of medical candidates, we should also do our best to make sure that other candidates are sound on such subjects as vaccination and experiments on animals.

I am, Sir, yours truly, CRITICUS, M.D.

# PURULENT CONJUNCTIVITIS OF INFANCY. To the Editor of The Medical Press and Circular.

SIR,-I see that the Council of the Association have appointed a sub-committee, under the name of "Ophthalmia Neonatorum," to inquire into the incidence of the purulent conjunctivitis of infancy. strongly suggest that the first matter to which that sub-committee should address its attention is that of assigning to the disease the name which correctly describes it. The term "ophthalmia" owes its origin to ignorance. In these days it implies nothing. For ages, through ignorance, it was appended to many diseases of the eye, such as rheumatic ophthalmia, arthritic cphthalmia, gonorrhoeal ophthalmia, "strumous" ophthalmia. All these expressions have, with increased knowledge, passed out of use, and to the diseases in question the correct definition has been given. The continued use of the word "ophthalmia" as applied to the conjunctivitis of infancy is, I contend, largely answerable for the neglect and want of due recognition of the disease in the past, into which matters the sub-committee have been appointed to inquire. Upon the term has been built a superstructure of mystery and misconception which has traditionally misled practitioners, midwives, and nurses into ignoring the true significance of the disease, and into believing that such cases, when they occurred, could be generically regarded as "only a little ophthalmia." What wonder, then, that so much blindness has resulted from the disease, under these circumstances? What wonder that practitioners should continue to overlook such cases, and midwives to persist in treating them with milk and cold tea until the vision has been permanently destroyed? Again I say, how can this be otherwise, as long as most ophthalmic surgeons, simply for the reason of paying tribute to that oftentimes irrational reason of paying thouse to that the term in although the term "ophthalmia" conveys. It has been held by some that the term is useful, as indicating a "generic" condition of conjunctival inflammation. I cannot conceive of a contention more inane than this. Just as well, for example, might it be argued that the old time expression "perityphlitis" should be retained to describe an attack of appendicitis. It is, however, of little avail, the present generation clinging tenaciously to the term "ophthalmia," for which, apparently, so much affection is displayed. In the next generation the word will have passed into that oblivion which constitutes the fate of all ignorance which knowledge has displaced.

But there is another aspect from which this question can be viewed. I allude to the complexity, the multitudinous variety of methods of treatment of cases of purulent conjunctivitis of infants. If in this day the question were categorically asked, "What is the expert treatment of this disease?" the answer can only be, "Oh, some ophthalmic surgeons use this 'ol,' some that 'ol,' some silver nitrate, some mercury perchloride. some repeatedly deluge the conjunctival sac with pints of potassium permanganate, and some resort to methods

of their own which do not see the light of publication." Amid such therapeutic chaos and unnecessary confusion, it is evident that the bad impression thus created by these diverse opinions could not fail to react harmfully upon the minds of those to whom the cases first come for treatment. Apart, however, from the conclusions at which the sub-committee upon the purulent conjunctivitis of infants may happen to arrive, we must still regard the matter, not merely as a national, but as a racial one—that is, which affects humanity at large. Well, therefore, would it be if at the forthcoming meeting of the International Ophthalmological Congress, a sub-committee were to be appointed, to agree, first, upon the proper terminology of the disease, and, secondly, to draw up a definite schedule of treatment which would serve as an authoritative expression of opinion, to be incorporated in all future text-books, and to be regarded as the standard loyally adopted and advocated by ophthalmic surgeons throughout the world. This would constitute the first definite step in the organisation of a system designed for the purpose of checking the ravages of this fateful On the other hand, it is impossible to anticipate beneficial results from any action which may be taken in this regard until the matter has been placed upon the firm basis of organisation.

Lastly, so far as the suggestion is concerned of attempting to secure legislation for the betterment of the present deplorable results of the purulent conjunctivitis of infancy—to that I am opposed. Legislation may in the future prove to be necessary, but its advocacy at the present moment is certainly premature. To the common-sense legislator the ordinary question would first suggest itself, "Have ophthalmic surgeons exhausted the means at their command to guide the profession and others concerned towards the proper realisation of the significance of the disease, its prevention and treatment?" I, as an ophthalmic surgeon, feel bound to submit that the answer must be in the negative, and partly for the reasons which I have indicated above.

dicated above.

I am, Sir, yours truly,

PERCY DUNN.

Wimpole Street, London, W.

# TESTING DISINFECTANTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Anent Mr. Walker's letter in your issue of January 27th, it seems to me that his methods in controversy are no sounder than his practice in the art of testing disinfectants, and that, directly his methods are exposed, he complains of personalities and charges his critics with "deliberate attempts to distort facts," whereas his own methods have very properly brought the criticism upon his head.

He has applied the Rideal-Walker test to various disinfectants, and published results, the accuracy of which has been disputed; he has compared various preparations by this test which should not have been compared with each other under the conditions imposed by him, and in some instances he has applied the test to certain sanitary preparations to which it is not properly applicable, apparently for the sake of unduly appraising his own company's manufactures at the expense of others, rather than by way of an "honest attempt to grapple with a serious and difficult problem in a scientific manner."

In a scientific manner."

In substantiation of my charge, I may recall my challenge of the accuracy of his examination of "Sanitas-Okol," which I backed by a financial consideration in aid of the King's Hospital Fund, which he shirked (Sanitary Record, Sept. 26th, 1907), and I may remind your readers that he has never compared other manufacturers' disinfectants of the coal tar order with Jeyes' Fluid—an article of his company's manufacture labelled poison, which is extensively advertised to the public, and which, with a co-efficiency of 2½ by the said test, has been sold for years past without any guarantee of co-efficiency—but always with "Cyllin," which, although advertised to the medical profession, is little known to the public at large.

is little known to the public at large.

As to the final part of my charge, it is well-known and recognised by chemists that the Rideal-Walker test is applicable to but few other than coal tar disin-

fectants, and Mr. Walker has again and again issued reports giving the results of the test as applied to other preparations, the disinfectant value of which cannot possibly be gauged by it, always again in comparison with "Cyllin"—a preparation which is amenable to the

The Rideal-Walker test has a value, of great limitations, but it is perfectly useless for determining the value of many disinfectants which are quite as serviceable as coal tar preparations, or more so. Mr. Walker should know this perfectly well, if he bases his claims for personal consideration upon a knowledge of chemical as well as bacteriological science.

As for the alleged common hospital practice of allowing a mixture of emulsified disinfectant with water to stand 24 hours before use, if it be true—as I fear it is-it is, all the same to be lamented, for all such mixtures, so far as they are used at all, should

be freshly mixed each day.

To exemplify the misleading nature of the Rideal-Walker test as often applied in practice, it will suffice to give an instance. Dr. W. C. Hossack, District Medical Officer of Calcutta, has found by a series of medical Omeer of Calcutta, has found by a series of carefully conducted experiments that one of the cheapest disinfectants manufactured by this company, viz., "Sanitas Soluble Fluid, B quality," having a coefficient of about 2, as determined by this test, is much more efficacious as a pulicide (for destroying fleas on rats) than "Cyllin," with a co-efficient of, say, 15. Here is an instance of one application of a disinfectant that cannot be gauged at all by the Rideal-Walker test.

As further instances, it may be mentioned that the disinfectant values of the following substances cannot districtant values of the following substances cannot be determined by this test—viz., chlorine preparations, sulphurous anhydride, formaldehyde, manganates and permanganates, peroxide of hydrogen and its compounds, such as "Sanitas Fluid." I particularly emphasise peroxide of hydrogen because it is one of the most serviceable disinfectants, even in dilute solutions, for dressing wounds and suppurating tracts, etc.; and yet, when tested by the Rideal-Walker method, it would appear to have very little value, as ascertained by a number of experiments made in my own laboratory.

Again, it is easy to show by the test under discussion that a disinfectant, which we may call A, may have a higher co-efficient than another one, B, but it is quite possible that B may, all the same, be preferable for certain purposes. Further, all such strong germicides have to be mixed with large quantities of water before use, and the selling price of B, which is under the control of its makers and not of the makers of A, may be such that it is much cheaper to use, even if not better than A from other points of view. In any case the makers of A have no right to damage the reputation of B by making and publishing any such comparisons as those, the subject of complaint.

Summing up the situation, it seems to me that the Rideal-Walker test, as applied by Mr. Walker, has proved very much more harmful than useful. All comparisons of the kind he has made are odious, and as there is plenty of scope for scientific progress and reward in the preparation of disinfectants and sanitary appliances without decrying one's neighbour's goods, Mr. Walker would be well advised by abstaining in future from a practice which is unfair to his competitors in business, misleading to the medical profession and public, and certainly not in keeping with the best English traditions of fair trading.

I am, Sir, yours truly,
C. T. KINGZETT, Chairman,
(for the "Sanitas" Co., Ltd.).

# OBITUARY.

GEORGE EASTES, M.B.LOND., F.R.C.S.ENG., L.R.C.P.

WE regret to announce the death of Mr. George Eastes, at the age of 67, at his residence in Paddington, London. At the annual election of Fellows to the Council of the Royal College of Surgeons, in July last, Dr. Eastes was the selected candidate to represent the general medical practitioners of London, and the result of the poll showed him to have been only 11 votes

behind the last of the four successful candidates. He was a regular contributor to medical journals, and wrote many articles of interest to non-medical readers concerning vaccination and physical recreation. Eastes was educated in Paris, and pursued his medical studies at Guy's Hospital, where for two years he held the posts of house-surgeon, surgeon-registrar, and tutor. He was treasurer of the Metropolitan Counties' branch, and member of the Council of the British Medical Association, a past-President of the Harveian Society, a Fellow of the Royal Society of Medicine, and for fourteen years was chloroformist to the Great Northern Hospital. Dr. Eastes' qualifications included: Fellow of the Royal College of Surgeons, Bachelor of Medicine of the University of London, and Licentiate of the Royal College of Physicians. He leaves one son, the well-known pathologist.

# SURGEON-MAJOR T. J. TUCKER.

SURGEON-MAJOR THOMAS JOHN TUCKER, who died on January 27th, at his residence, Dean House, Hindon, was a veteran of the Indian Mutiny. Born in 1828, he entered the Army as an assistant-surgeon in July, 1855, entered the Army as an assistant-surgeon in July, 1655, serving in the 31st Regiment. He was present when three native regiments mutinied at Dinapur on July 25th, 1857, and at the defeat of the rebels under Koer Singh with the capture of Jugdespur in the following August. In February and March, 1858, he took part in the advance to Lucknow, and was present at the actions at Chanda, Umeerpur, Sultanpur, and Duraha, and at the siege and capture of Lucknow. For his services he received the Mutiny medal and clasp. In November, 1869, he became surgeon of the regiment, and in May, 1877, retired.

#### FRANK UTTEN PURCHAS, M.B., C.M.EDIN.

WE regret to record the death of Dr. F. U. Purchas, of Newton, which took place at the age of 48. He was born in Dry Harbour, Jamaica, and, coming to England for his education, determined to enter the medical profession. He studied at Edinburgh University, where he graduated in 1887. In 1888 he went to Newtown as assistant, and later became a partner with Dr. F. Ferguson. Some years after this Dr. Purchas acquired the entire practice, and afterwards took into acquired the entire practice, and afterwards took into partnership Dr. Shearer. Amongst the public appointments held by Dr. Purchas may be mentioned senior medical officer to the Montgomeryshire Infirmary, certifying surgeon under the Factory Acts, parish medical officer for Bettws and Llanllwchaiarn, and medical officer for the post-office. He leaves a widow and one daughter.

GEORGE WATT, M.D.ABERD., J.P. WE regret to announce the death of Dr. George Watt, of Aberdeen. Dr. Watt, who was 61 years of age, was a native of Donside, and came to Aberdeen in the late 'sixties. He entered Marischal College as a medical student, and graduated M.D. in 1876. He left Aberdeen for Loftus, Yorkshire, where he remained four years. In 1880 he returned to Aberdeen, and settled down to the practice of his profession. For many years he was on the staff of the Dispensary; he was medical officer for Blairs College and Nazareth House; sole referee in the Aberdeen district for the Prudential Assurance Company; and he was also medical officer for a number of industrial societies. An ex-President of the Aberdeen Medico-Chirurgical Society, he continued until the last to take an interest in its work, and he was the treasurer of the Widows' Fund of that society, and even in his weakness he would not be relieved of the duties of that office, so much did he like the work. He was a J.P. of the city. Dr. Watt was a man of unassuming and peace-loving disposition, and by his professional brethren he was held in the highest esteem, and they ever looked upon him as a man incapable of exciting ill-feeling or jealousy.

PROF. HENRY E. CLARK, F.R.C.S.Ed., of Glasgow. The death of Mr. Henry E. Clark will be deplored by medical graduates of Anderson's College and St. Mungo's College all over the world, where he laboured

so conscientiously as Professor of Anatomy and Surgery for many years. Being a splendid anatomist, he was a fearless and bold operator. He never got into a muddle or lost his head. He successfully removed the arm and scapula for a large sarcoma on the shoulder. He was particularly successful with cases of excision of the rectum for cancer. He never failed to interest and amuse, as well as to instruct his students, as he was amuse, as well as to instruct his students, as he was brimful of good humour and capital stories. He was a man of most exemplary character, abstemious, prompt, and punctual, and duty-loving. Being an omnivorous reader, he was buoyant in mind to the last, and could lift his mind from grave to gay in an instant. His memory will be long cherished, and will be associated with that of a brave surgeon and a good man. His name came specially into prominence at the time of the South African War in connection with the Scottish National Red Cross Hospital, of which he was placed in charge. On his return to this country he received the C.M.G. in recognition of his work at Kroonstad.

# SPECIAL ARTICLES.

## THE HEALTH OF THE NAVY

THE Report on the Health of the Navy for 1907 (a) is a much smaller volume than we have been accustomed to in previous years. Thus it contains only 108 pages and costs 7d., as against the Report for 1904, which contained 197 rages and cost is 11d. The information given is of a scanty nature, and the Scientific Appendix contains only two brief notes, one by Staff-Surgeon Whiteside on the work of the Royal Naval Hospital, Malta, and the other by Staff-Surgeon Rees on Air in Double Bottoms of Iron Ships. In former Reports we had perhaps ten or twelve papers, many of them of real scientific value. Of course, it may be admitted that a Blue Book is not a good medium for the publication of scientific papers, but we hope that the docking of the Blue Book of this feature only means that some other channel of publication has been

found for the work of naval surgeons.

We are glad to note that the classification of diseases has been made to comply with the 1906 edition

of the "Nomenclature of Diseases."

The returns for the total force for the year 1907 show an improvement on the Report of the previous year, the average loss of service for each person having

dropped to 10.46 days.

The total force, corrected for time, in the year 1907, was 108,740, and the total number of cases of disease and injury entered on the sick list was 75,351, which is in the ratio of 692.94 per 1,000, showing a decrease of 85.23 per 1,000, as compared with the average ratio of 85.23 per 1,000, as compared with the average ratio of the last 5 years. The number of entries per man for disease and injuries was:—On the Home Station, .66; Channel, .57; Atlantic, .66; Mediterranean, .68; North America and West Indies with Fourth Cruiser Squadron, .96; China, .98; East Indies, 1.03; Australia, .85; Cape of Good Hope, .71; and Irregular List, .97. For the total force the average is .69, a fractional decrease on the previous year's figures. The fractional decrease on the previous year's figures. The average number of men sick daily was 3,118.4, giving a ratio of 28.67 per 1,000, a decrease of 3.52 per 1,000 in comparison with the last 5 years' ratio.

The total number of deaths was 365, giving a ratio

of 3.35 per 1,000, showing a decrease of 1.05 in comparison with the average ratio for the last 5 years. Of this number 246, or 2.26 per 1,000, were due to disease, and 119, a ratio of 1.09 per 1,000, to injury.

Of the principal diseases recorded, we find that there were 2,501 cases of influenza; 166 of enteric fever, with 24 deaths; 441 of pneumonia, with 31 deaths; 371 of malaria, with 1 death; 305 of tuberculosis, with 30 deaths; 13,522 of venereal diseases, with 8 deaths; 849 of nervous diseases, with 9 deaths; 618 of diseases of the circulatory system, with 43 deaths; 7,179 of respiratory diseases, with 13 deaths; 11,010 of diseases of the digestive system, with 27 deaths; 19 cases of suicide occurred. Including these, there were in all 116 deaths by violence. Of Malta fever 29 cases are

(a) Navy (Health). Statistical Report of the Health of the Navy or the Year, 1907. London: H.M. Stationery Office. 296. Price 7d.

recorded, with 5 final invalidings and 2 deaths. In comparison with the average ratios for the last 5 years, the case ratio has fallen from 3.47 per 1,000 to .26, the final invaliding from .13 to .04 per 1,000; and the death from .06 to .01. Of malarial fevers, 371 cases are returned, with 1 death. The case ratio under this heading was 3.41 per 1,000, in comparison with 6.71, the average ratio for the last 5 years. This reduction is greatly due to the withdrawal of ships from malarial districts on foreign stations, but partly also to the careful use of mosquito curtains, and of quinine as a prophylactic by ships serving in such districts. Of venereal diseases, the total number of cases recorded is 13,522—viz., chancroid, 1,905; syphilis primary, 1,461; syphilis secondary, 3,215; gonorrhœa and its sequelæ, 6,941 cases. The final invalidings were: syphilis secondary, 163; gonorrhœa and its sequelæ. 50. Syphilis secondary gave 6, and sequelæ of gonorrhœa 2 deaths. The total number of days' loss of service was 329,936, while the average daily number from interfective from these discourse value. of men ineffective from these diseases was 903 9. The case ratio shows a decrease of 1.58 per 1,000, and the ratio per 1,000 of men daily ineffective shows a fractional decrease, in comparison with the average ratios for the last 5 years. Australia again shows the highest case ratio.

# REVIEWS OF BOOKS.

THE PUBLIC HEALTH ACT. (a)

This book (a), of 385 pages, containing much valuable information, is arranged in four divisions:—
I.—An Introduction (67 pp.). II.—The Public Health Acts Amendment Act, 1907, with Notes (151 pp.). III.—A Summary of recent decisions and Appendix, containing Sections of the Public Health (Ireland) Acts, 1878 and 1896, referred to in the Act of 1907, and the Notes thereto; the Prevention of Infectious Diseases Act, 1890; and the General Dealers (Ireland)

Act, 1903 (65 pp.). IV.—An Index (102 pp.).
For the non-legal reader the Introduction is the most interesting portion of the book, as it clearly and concisely summarises and explains each of the ten parts into which this, much the longest of the Acts amending the Public Health Acts, has been divided. authors are so anxious to emphasise the fact that, none of the provisions of the Act save Part I. take effect in any district till they have been applied by the Local Government Board or Chief Secretary, while they deal with each section as if it was in force, that they reiterate the statement on pages 3, 5, and 6. In Part I. the procedure for the application of the Act, or part of it, in a district, and in Part II. the Regulations for buildings and streets are explained. Part III. is concerned with more strictly sanitary matters, such as nuisances, drains, sinks, water-closets, urinals, public conveniences, and ambulances, and the provisions of the Act under each heading is fully discussed. Attention is called to a curious omission in the Act, that, while the local authority may contribute to the, or pay the entire, cost of altering unsatisfactory closets in existing buildings, that power is not extended to providing closets in buildings where there are none.

The arrangement of the sections of the Act in Part IV. dealing with infectious diseases is very hap-hazard; they are therefore re-arranged for consideration under the headings of (a) Control conduct, both general and in relation to common sources of infection; and (b) direct action by the local authority. Under (a) come exposure of persons suffering from infectious disease,

dairies, laundries, schools, libraries, etc.

With regard to schools, the writers point out that
Section 57 of the present Act, although it may be
applied to Ireland, is designed to introduce provisions against sending infected children to school, similar to those in our Public Health Act, into England. It is well to note that under the Act the medical officer of the district is to give certificates free of charge. Under (b) is included the cleansing or disinfection of

<sup>(</sup>a) "The Public Health Acts Amendment Act, 1907." By Arthur E. Clery, LL.B., and J. C. McWalter, M.A., M.D., D.P.H. Dublin: Edward Ponsonby. 1908. Price 2s.

infected premises, the removal of persons from unfilthy articles, and the cleansing and disinfecting of healthy houses, the removal of infectious patients to,

and the provision of, hospitals.

In Parts V. to X. the sections of the Act concerning lodging houses, recreation grounds, police and traffic, trades, servants' registries, marine dealers, sky signs, fire brigades, bathing, pleasure boats and boatmen—subjects rather outside the scope of Public Health are dealt with.

The Act itself is fully annotated, and cross references are made in both the Introduction and in the

portion devoted to the Acts.

There are a few repetitions which might well have been omitted—for example, those we have before referred to; the removal of persons, on page 44, which is treated of in a paragraph below on the same page; and the schedule of references to the Public Health

(Ireland) Act, 1878, which is printed twice.

The work has been well done. A great amount of important matter has been adequately and intelligently treated in an understandable way, in a small volume, which will be found of service to, and should be in the hands of all, medical officers of health and sani-

tary authorities.

## FIRST LINES IN DISPENSING. (a)

This small work is intended to serve as an introduction to the art of dispensing for students and nurses. Students, especially, have little or no idea as to how to make pills, ointments and other pharma-cal preparations. The result is that they are unable to write prescriptions, the ingredients of which are compatible. We are strongly of opinion that it would be an excellent thing if every medical student were examined in practical pharmacy during his final year. At all events more attention should be paid year. At all events, more attention should be paid to the subject during the ordinary curriculum. This volume contains all that the average student or medical practitioner needs to know on the subject. We notice that Mr. Lucas advocates the use of a porcelain capsule for the preparation of suppositories, and this we find is a very simple method and works well in practice. At the same time many examiners insist on the use of a water bath. Consequently we advise that in future editions a full account of this mode of manufacture should be inserted. At present mention is merely made of the use of a water bath for this purpose.

A very good account is given of the mode of pre-paration of so-called "percentage solutions," which often give the student considerable trouble. Although the work is stated in the preface to be merely an "introduction to the subject" of which it treats, we feel certain that it is just the sort of text-book to recommend to students of medicine. A careful study of its pages will lay a solid foundation for practical The teaching is sound, and the explanations given of the various manipulations are always clear and practical. The book is copiously illustrated, and contains a short appendix on poisons and their anti-

# ROTUNDA MIDWIFERY FOR NURSES AND

MIDWIVES. (b)

This small book, which Dr. Wrench has published with the object of simplifying the studies of nurses and midwives, is decidedly good. The teaching of the book is that of the Rotunda Hospital, and the author has considered his subject with the rules and regulations of the Central Midwives' Board always in view, so as to define carefully what treatment is within view, so as to define carefully what treatment is withing the scope of a midwife, and to point out when medical aid is to be sent for; thus, midwives who follow the advice given by the author will avoid contravening the regulations and endangering their own licence to prac-tice either through ignorance of the limitations put upon the duties of midwives, or through over-zeal and

a desire to retain the entire management of a case in their own hands.

There are a few minor points in the book which are open to criticism. The position in transverse presenta-tion is defined by the direction of the back alone; this does not convey much information unless the position of the head is also mentioned. In the methods of saving the perinæum no reference is made to the use of the right hand; its position is shown in the illustration, but the text does not say what it is there for. How to fit the binder does not conform with the method of the Rotunda unless this has been changed very recently; the chief point was the fixing of the third pin above the fundus of the uterus when it is contracted.

Another important omission is the second ligature applied to the cord at the time the baby is being bathed, which is always adopted in the Rotunda as a necessary and excellent precaution, especially in a visiting case. Complete and incomplete breech are reversed in the description of the presentation, and the illustration follows in the error.

The description of how to bring down extended arms might be fuller, as the complication must be dealt with promptly by the nurse; the importance of passing the fingers up to the forearm of the child is not mentioned. In manual removal of the placenta the author says:
"When you think you have separated the whole placenta, pull it away." This is not good advice. The operator should make sure the placenta is all detached, and then express the hand and placenta by pressure over the fundus of the uterus. The illustration shows the right way to express the hand and placenta.

The chapters on the care of the infant, both healthy and unhealthy, are excellent and full of sound advice. There is only one statement to take exception to, which is: "After the end of the first month let the baby be fed every three hours during the day." These intervals are too long.

These criticisms are not made with any idea of depreciating the value of this book. The work is carefully produced, and the teaching sound, whereas the errors referred to are very few and on minor points.

# MEDICAL NEWS IN BRIEF.

Sanitary Inspectors' Association.

THE 26th annual dinner of this Association was held at the Gaiety Restaurant on Saturday last, the President, Sir James Crichton-Browne, occupying the chair. Sir Alfred Keogh, Director-General of the Army Medical Department, appealed for 2,000 men for the sanitary service of the Territorial Army. Sir James Crichton-Browne said that in no branch of science had advance during the last 50 years been more decisive than in sanitation and the public health. But there was no finality in sanitation; on all hands problems-pressed for solution. Looking forward, one could see-that the advance of aeronautical inventions would involve an entirely new system of sanitary regulation. In regard to dust raised by motor-cars, the visible dust kept the nation sneezing, coughing, and sniffling; but after the visible dust subsided clouds of invisible dust hovered about. The improved sanitation of modern times gave confidence when danger threatened, pre-venting that panic in the presence of epidemics which had often resulted in mental overthrow. The President, on behalf of the Association, presented to Mr. G. Anderson, Chief Sanitary Inspector of Middlesbrough, an illuminated address, cases of cutlery, and a diamond ring, to mark appreciation of services rendered during 16 years as chairman of the north-eastern centre, member of the central executive, and chairman of the council during the years 1906-8.

#### Priendly Societies and Medical Men.

ORGANISED by the Charity Organisation Society, a conference was held on Saturday to discuss the question of friendly societies and the medical profession.

Dr. James Pearse, M.D., said the profession did not object to the principle that friendly societies should provide medical attendance for their members.

<sup>(</sup>a) "First Lines in Dispensing." By E. W. Lucas, F.I.C., F.C.S., Pharmaceutical Chemist, late Examiner to the Pharmaceutical Society of Great Britain. London: J. and A. Churchill. 1908.

(b) "Rotunda Midwifery for Nurses and Midwices." By E. T. When M. D., late Assistant Master, Ectunda Hospital. Pp. 294, 115 illustrations. London: Henry Frowde, Hodder and Stoughton. 1908.

objected to the details by which the principle was carried out. He gave as an instance that, taking the average of the friendly societies, the fee paid by members for medical attendance was 5s. per annum, and the practitioner had to supply free drugs and surgical dressings. He referred to the injustice of members in receipt of good incomes going upon the club. One such man was chief manufacturer in his district, and kept hunters, while another left estate valued at £80,000.

Sir Thomas Smith, F.R.C.S., deplored that there was no board of conciliation to settle the dispute between the societies and doctors. Sir Thomas Barlow, M.D., F.R.C.P., appealed to the sense of right and justice of skilled artisans to remember that very often the doctor did not get remunerated. Doctors deserved a living wage. Mr. R. W. Moffrey (Manchester Union of Oddfellows), on behalf of the societies, promised that, with a view to a settlement of the dispute, the National a view to a settlement of the dispute, the National Conference of Friendly Societies would receive a deputation of doctors. Dr. Smith Whitaker said no amicable adjustment could be arrived at unless friendly societies were prepared to accept a wage limit, by which all members receiving an income above a certain amount should not receive the attendance of the medical officer. medical officer.

#### British Medical Benevolent Fund.

A MEETING was held yesterday at the Royal College of Physicians on behalf of the British Medical Benevolent Fund, which was established for the relief of medical men, their widows, and children when in

The chair was taken by the President of the fund. An address was delivered by the Bishop of Oxford, supcollege of Physicians, and others. The fund was founded in 1836, so that for more than 72 years it has continued its beneficent work. It has slowly accumulated invested funds, out of the income of which it now supports 126 annuitants, spending in this department about £2,500 annually. No candidate under the age of 60 is eligible for an annuity. Many distressing cases, however, occur at a much earlier age, and for these relief has to be provided from the subscriptions and donations of the year, which are a fluctuating item of income. The grant department of the fund has caused much anxiety to the managers, for the capacity of the fund for good is limited by the contributions for the year. The main support of the fund comes from the medical profession itself, and little is given by the public at large. Yet, it is urged, there is no profession which does so much for the public with so little or no remuneration. The managers believe that the work and objects of the fund only require to be known and realised for the financial support which is necessary to be forthcoming.

The investments are placed in trust securities. The

accounts are audited every year by chartered accountants, and the working expenses are under 6 per cent. Contributions may be sent to the hon. treasurer, Dr. Samuel West, 15 Wimpole Street, London.

Marathon Racing.
"We have no hesitation in saying that we consider that school and cross-country races exceeding one mile in distance are wholly unsuitable for boys under the age of 19, as the continued strain involved is apt to cause permanent injury to the heart and other organs." This statement in condemnation of long-distance racing for boys, signed by Sir Lauder Brunton, Sir Thomas Barlow, Sir Alfred Fripp, Dr. James F. Goodhart, and Dr. W. Hale White, is being sent to every headmaster in the United Kingdom and the Colonies by Mr. J. Herbert Farmer, captain of the Old Harrovians and the Middlesex County Football Club from 1886 to 1891.

#### Prevalence of Mossles.

LONDON's annual death-rate the week before last, according to the Registrar-General's return, was 17.8 per 1,000, having been 18.0, 16.9, and 15.3 in the preceding three weeks. The total number of deaths registered was 1,653, and the births 2,110. There were 82 deaths from measles, compared with 76 in the previous week. In the 76 great towns of England and Wales the annual death-rate per 1,000 of their aggregate population was 18.0; in the preceding three weeks it had been 17.5, 16.6, and 15.7.

#### Reyal University of Ireland.

AT a meeting of the Senate, held on February 5th, 1909, the following examiners were appointed:—In Physiology: Thomas H. Milroy, M.D. Medicine: James A. Lindsay, M.A., M.D., and Joseph F. O'Carroll, M.D. Surgery: Thomas Sinclair, M.D., M.Ch. Ophthalmic Surgery: Arthur W. Sandford, M.D., M.Ch., and Louis Werner, M.B. Midwifery: Sir John W. Byers, M.A., M.D., M.A.O., and Alfred J. Smith, M.B., M.Ch., M.A.O. Medical Jurisprudence and Sanitary Science: Patrick T. O'Sullivan, M.D., and James N. Meenan, M.B., D.P.H. Materia Medica: Martin Dempsey, M.D., and Sir William. Whitla, M.A., M.D. Pathology: Edmond J. McWeeney, M.A., M.B., Arthur E. Moore, M.B., B.Ch., B.A.O., and W. St. Clair Symmers, M.B. Sanitary Science: Sir Charles A. Cameron, C.B., M.D. Mental Diseases: George Revington, M.D., and J. O'Connor Donelan. AT a meeting of the Senate, held on February 5th, J. O'Connor Donelan.

#### Conjoint Examinations in Ireland.

The following candidates have passed the Third Professional Examination held by the Royal College of Physicians and Surgeons:—G. F. Allison, A. D. Clanchy, M. M. E. Coghlan, O. G. Connell, C. A. Farrell, J. W. Flood, F. H. Gleeson, P. Harrington, J. P. Johnston, D. J. Lyne, J. Mitchell, F. J. McManus, J. H. O'Neill, R. P. Thomson, H. Q. O. Wheeler, J. McG. Williams.

The following candidates have passed the Supplementary of the collowing candidates the collowing candidates th

The following candidates have passed the Supplemental Preliminary Examination:—T. S. Ambrose, J. F. J. Carroll, M. Cahill, J. J. Cosgrove, J. P. Grimes, J. M. Marron, P. W. O'Connor.

# Indian Medical Service.

At the competitive examination for commissions in the Indian Medical Service, held on January 25th and five following days, 32 candidates presented themselves for 12 vacancies. The following is a list of those who were successful, arranged in the order of merit:—Henry Charles Semon, M.A., Oxford University and University College Hospital; Vinayak Balvant Gokhale, University College Hospital; Vinayak Balvant Gokhale, Bombay University and University College Hospital; Andrew Monro Jukes, St. Bartholomew's Hospital; Gwilym Gregory James, Westminster Hospital; William David Keyworth, B.A., Cambridge University and Charing Cross Hospital; Berkeley Gale, M.B., Glasgow University; John Howard Horne, M.B., Edinburgh University; Harold Holmes King, M.B., St. Bartholomew's Hospital; Mozaffer Din Ahmed Kureishi, King's College Hospital; Richard Edward Flowerdew, M.B., Aberdeen University and St. Thomas's Hospital; M.B., Aberdeen University and St. Thomas's Hospital; Alfred John Lee, M.B., University College Hospital; John Glendinning Bryden Shand, M.B., Edinburgh University and Extra-Mural School.

An inquest was held at Clerkenwell, on Feb. 2nd, on the body of an infant whose death was mainly due to inflammation set up in a way which for some time could not be accounted for. It was eventually ascertained that the mother had washed the child's clothing in a strong bleaching powder which contained alkali as one of its ingredients, and a doctor said that this caused an irritation which eventually resulted in very bad inflammation.

At the Warneford Hospital, Leamington on February 3rd, a portrait in oils of Dr T. W. Thursfield, senior honorary physician to the hospital, painted by Miss Edwards, was presented to the hospital, and was hung in the Board Room. Major Chesshyre Molyneux (chairman of the committee) presided and made the presentation. He said that in recognition of Dr. Thursfield's valuable services as their honorary physician, the portrait was presented by his colleagues of the staff and committee, and by other friends.

# **NOTICES TO** CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Instial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Books, &c.:—Seven lines or under (70 words), 4s. &d. per
insertion; 6d. per line beyond.

DR. SLINGSRI.—Has our correspondent tried the new test for suspected pancreatic disease? It is simple, and is said to be likely to prove perfectly trustworthy. A few drops of adrenaline solution are placed in the conjunctival sac of the patient: after a brief interval, should diabetes or pancreatic tumour be present, a marked mydriasis is observed. On the other hand, no dilatation of the pupil occurs when the pancreas is unaffected. OMEGA.—Whether aphasia is or is not associated with hemiplegia is merely a question of the extent of the primary lesion.

SIR CHARLES BALL ON THE RECTUM.

SIR CHARLES BALL ON THE RECTUM.

WE desire to correct two errors which were allowed to appear in our review of this very excellent work. Fig. 60 was by a slip described as a micro-photograph, whereas, as is mentioned beneath it, it is a drawing made by the aid of the camera lucida. We also were in error in thinking that Fig. 59 had been inadvertently turned upside down. That is not so. The photograph was originally taken from behind, with the patient in a stooping position. Contrasted with Fig. 59, it gave us the impression that it had been reversed. The position of the scrotum, however, obviously shows that this is not so.

LAY READER (London).—The nutrient qualities of "Mellin's Food" render it suitable for use, both by invalids and nursing mothers. A postcard directed to the firm, desiring further information, would, no doubt, secure for our correspondent a copy of the published reports upon this excellent preparation.

Mrs. S. L. P.—The active ingredient in the preparation is eucalyptus oil, which is a mild antiseptic, and a slight stimulant

# Meetings of the Societies, Tectures, &c.

WEDNESDAY, FERBUARY 107E.

ROYAL SOCIETY OF MEDICINE (MEDICAL SECTION) (20, Hanover Square, W.).—5.30 p.m.: Discussion: On Ulcerative Collitis (adjourned from January 26th) will be continued by Sir Patrick Manson.

Manson.

UNITED SERVICES MEDICAL SOCIETY (Royal Army Medical College, Millbank, S.W.).—5 p.m.: Clinical Demonstrations.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Waler's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

TRUREDAY, PERRUARY 11TH.

BOYAL SOCIETY OF MEDICING (UNSTETRICAL AND GYNECOLOGICAL SECTION) (20, Hanover Square, W.).—7.45 p.m.: Specimens: Dr. Herbert Spencer: A Venous Aneurysm on a Uterine Fibroid. Mrs. Stanley Boyd: A Necrobiotic Fibroid. Dr. Victor Bonney: A Modification of "de Ribes Bag." Dr. F. E. Taylor: A Uterus with Two Interstitial Fibroids; one showing Red Degeneration, the other Normal. Dr. Drulamond Maxwell: Notes on a Case of Toxic Vomiting and Pregnancy. Short Cummunications: Dr. F. J. McCann: Sarcoma of the Fallopian Tubes. Dr. Russell Andrews: Some Cases of Vesicular Mole in Combination with Ovarian Cysts, together with Cases Recorded. Paper: Dr. G. F. Blacker: A Case of Hydetiform Mole with Albuminuria of Kiduey and Pregnancy; Sudden Death from Cardiac Fallure.

OPHTHALMOLOGICAL. SOCIETY OF THE UNITED KINODOM (11, Chandos Street, Cavendish Square, W.).—8 p.m.: Clinical Evening, Cases, etc., will be shown by Mr. N. B. Harman, Mr. A. Levy, Mr. J. F. Cunningham, and Mr. E. Nettleship.

ORILD SYLDY SOCIETY LONDON (Parkos Museum, Magaret Street, W.).—8 p.m.: Causserie: Reception of American Teachers. NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Walse's General Hospital, Tottenham, N.).—2.30 p.m.: Gynecological Operations (Dr. A. E. Glies). Clinics: Medical Out-partent (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X.Rays. 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lantern-Lecture: Mr. H. Evans: Applied Anatomy of the Breast: Diseases of the Male Breast.

Fr. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.).—6 pm.: Chesterfield Lecture: Treatment, Constitutional and Local, in all its Forms.

Friday, Friedury 12Th.

Royal Society of Middicker (Clinics: Bection) (20, Hanover)

FRIDAY, FERRUARY 12TH.

ROTAL SOCIETY OF MEDICINE (CLINICAL SECTION) (20, Hanover Square, W.).—8 p.m.: Cases: Dr. H. Morley Fletcher: Cases of

Oxycephaly. Dr. Herbert P. Hawkins: Case of Leprosy. Mr. W. Sampson Handley: Elephantiasis treated by Lymphangioplasty. Mr. P. M. Heath: (1) Diffuse Periostitis of both Tibles without Other Evidence of Congenital Syphilis; (2) Congenital Syphilitis (English Swelling of the Hands (Trophosdema): Congenital Splenomegaly and Scholurio Jaundice. Dr. F. J. Poynton: Amaurotic Family Idiocy. Dr. M. Macnaughton-Jones, jun.: An Automatic Appliance for Maintaining Pressure in carrying out Bier's Treatment. Mr. R. Higham Cooper: Acromegaly with Unusual Bone Changes. 8.30 p.m.: Mr. Butlin will Exhibit his Collection of Drawings of Early Carcinoma of the Tongue and of Conditions which may be Mistaken for it; and will speak of the Results of Operations which have been practised in the cases exhibited. Microscopic sections of the cases will be on view. 9.40 p.m.: Mr. R. J. Godlee will describe a Case of Dermoid Cyst of the Mediastinum treated by Operation, and will illustrate the subject of this operation by a Pathological Specimen from another case.

NORTH-EAST LONDON POST GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.)—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks) 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

ALLISON, T. M., M.D., B.S.Durh., Honorary Assistant Physician to the Royal Victoria Infirmaty. Newcastle-on-Tyne.

GORDON, J. E., M.D., Medical Superintendent of the Devon and Cornwall Sanatorium.

MYLER. JOHN WILLIAM GLENTON, M.D.Brux., F.B.C.S.Eng..
L.R.C.P.Lond., D.P.H.Lond., Medical Inspector of Schools by the Rhondda Glamoryanshire) Education Committee.

YOUNG, JAMES, M.D., C.M.Glasg., Physician to the Handel Cossham Memorial Hospital, Bristol.

# Vacancies.

Parish of St. Marylebone.—District Medical Officer. Salary, £200 per annum. Applications to Henry T. Dudman, Clerk to the Board, Guardians' Offices, Northumberland Street, Marylebone Road, W.

Road, W. Parish of St. Marylebone.—Visiting Medical Officer. Salary, £200 per annum. Applications to Henry T. Dudman, Clerk to the Board, Guardians' Offices, Northumberland Street, Marylebone Road, W.

Board, Guardians' Offices, Northumberiand Street, Marylebone Road; W.

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West Riding Asylum. Wakefield.—Pathologist and Assistant Medical Officer. Salary, £250 per annum, with board, furnished apartments, and attendance. Applications to the Medical Director at the Asylum.

Roxburgh District Asylum, Melrose.—Assistant Medical Officer. Salary, £150 per annum, with board, rooms, and washing. Applications to the Medical Superintendent.

County Asylum, Mickleover. Derby.—Junior Assistant Medical Officer (Male). Salary, £120 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Durham County Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, laundry, and attendance. Applications to the Medical Superintendent, Durham County Asylum, Winterton, Ferryhill.

Northumberland County Asylum, Morpeth.—Junior Assistant Medical Officer. Salary, £120, with board, apartments, laundry, and attendance. Applications to the Medical Superintendent.

The Guest Hospital, Dudley.—Senior Resident Medical Officer. Salary, £100 per annum, with board, residence, attendance, and washing. Applications to the Secretary.

Brixton Dispensary.—Resident Medical Officer. Salary £150, with furnished apartments, attendance, coal, and gas. Applications to the Secretary, st the Dispensary, Water Lane, Brixton, S.W.

# Births.

AVILLIUS.

KATE.—On Feb. 1st, at Eaglestone, Strathpeffer, N.B., the wife of H. W. Kaye, M.D., of a son.

LANGDON-DOWN.—On Feb. 7th, at Dixlaud, Hampton Wiek, the wife of Percival Langdon-Down, M.B., B.U., of a daughter.

LETCHWOFTH.—On Feb. 2nd at St. Ives, Churchfield Road. Walton-on-Thames, the wife of T. W. Letohworth, M.B., of

# Marriages.

STEWART—MITCHEL.—On Feb. 2nd. at All Saints' Church.
Margaret Street, London, James Stewart, B.A., Q.U. Belf.,
F.R.C.P.Ed., formerly Surgeon R.N., of 24, Welbeck Street.
London (only son of the late Bobt. Stewart, M.D., of Belfast
District Asylum), to Edith Albertha, second daughter of the
late George Haslett Mitchel, Esq., of "St. Helen's," Bunorana, co. Donegal.

# Beaths.

ARCHIBALD.—On Feb. 4th at St. Regulus, Mayow Road.
Sydenham, in her 84th year, Anne Wemyss, widow of David
Archibald, M.D., St. Andrews, Fife.
Burron.—On Feb. 2nd, at St. Winifred's, Reigate, Joseph Stewart
Burron, M.R.C.S., L.S.A., late of Blackheath, fifth son of the
late Rear-Admiral George Guy Burton, in his 82nd year.

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, FEBRUARY 17, 1909.

No. 7.

# Notes and Comments.

An Appendicitis Dinner.

America is the chosen abode of freakishness, and in one of its most recently reported essays it has certainly lived up to its reputation. From a New York journal we learn

that a Philadelphia surgeon gave a dinner to patients upon whom he had operated for appen-The story tells that no fewer than 160 guests graced this eccentric banquet, a living and eloquent testimony of the skill of their dis-tinguished host. It is to be presumed that he alone would be conscious of the unseen failures who might possibly be hovering in the spiritual atmosphere of the banqueting-room. In any case, the number of operations mentioned can hardly be regarded as excessive for any surgeon who has been for any considerable length of time engaged in operating practice. The first operation for appendicitis appears to have been performed in New York in 1886, although it had been originated and practised in England some years previously by Sir Frederick Treves. In Philadelphia the first formal removal of the appendix appears to have taken place in 1887, and to have been then performed as a precautionary measure. Later the operation was undertaken in a wholesale fashion, and even now, although the craze has lapsed into saner moods, it seems not unlikely that the physician might be able to cure not a few cases that are handed over to the tender mercies of the surgeon.

Further

In spite of a chequered career, it is clear that the operation for appen-Side-lights on dicitis has saved tens of thousands the Appendix. of lives, and that it stands out prominently as one of the great ad-

vances of the marvellous century which produced Listerism. It is a matter, perhaps, for some little amount of self-congratulation that both discoveries should have emanated from the practical genius of our own countrymen. Curiously enough, the ætiology of appendicitis yet requires a good deal of illumination. In a general sense it seems more than probable that bacterial invasion lies at the root of the inflammatory process in a majority of That statement, however, does not help us much in the direction of prevention or of treatment -whatever its outcome may be in the more or less remote future. It is all very well to scoff at the public for their fixed belief in the agency of grapestones and other foreign bodies in the causation of the malady, but medical teaching, on the other hand, is still vague and unsatisfactory. As a matter of fact, out of 1,000 cases of appendicitis operated upon at the Johns Hopkins Hospital, foreign bodies were present in only four of the

whole number. The recent operation of appendicostomy although undertaken for causes other than inflammation of the appendix, has, we understand, already been somewhat extensively practised. Useful as it undoubtedly appears to be in suitable cases, we sincerely hope that it may never be permitted to lapse into that indiscriminate application which has cast somewhat of a slur upon operative surgery in the case of the removal of the appendix.

without Protection.

Pre-eminent tinually being told by one type of politician that British trade is on the down grade, and that the enterpris-

ing foreigner is ousting the nation of professed shopkeepers from their heritage, it is reassuring to learn that in the trade of surgical instruments the Britisher can hold his own in foreign markets, in spite of all disadvantages and restrictions. If this is the case, as we gather it to be from what has lately been written on the subject, it is certainly comprehensible, for most Britishmade surgical instruments, albeit very expensive, are of the finest quality and workmanship, and will hear comparison with those turned out by any nation. It seems that English scalpels and knives generally are especially esteemed, and that the demand for them among American surgeons is extensive. This is high commendation, coming as it does from a land which flows with iron and steel, and in which blast-furnaces on a prodigious scale have to work day and night to keep up with orders for rails, plates, and the coarser steel goods. The craft of surgical instrument-making, indeed, in this country has certainly reached a high pitch of perfection, and we understand that it is one of the few callings which is not over-stocked, as the difficulty of getting first-rate workmen is so great that an accomplished hand will never want for plenty of highly remunerative employment. When so many of the trades in which this country held pre-eminence for so long are being cut into, it is comforting to think that in this special line Great Britain more than holds her own.

Expensive

THE ways that they have in New York City, when compared with the

Expensive
Expectoration. conservative doings on "this side," possess a naïveté which is almost comic. It appears that the City Health Commissioner for that great centre has a "sanitary squad," one of whose latest duties is to institute prosecutions for spitting in public places. The squad took the aggressive last week, and netted no less than 200 persons who thus offended against hygiene and good taste. The culprits all committed their offences in railway trains and tubes, and we can candidly say that any sanitary squad which a medical officer of health over here turned on to the same job would receive our hearty support. It seems that the regulation against spitting has not been realised by the American public yet, and that it is something of a wrench for them to abandon so old-established and popular a national habit. When haled before the magistrate the only defence recognised was that the spitting was not done for pleasure, but for business, that is to say, that the prisoners were suffering from a cough. Even this was only admitted as an extenuating circumstance, and the valiant 200 were all fined a dollar, except those with coughs, who got off with half that sum. The campaign, which has been instigated by the American Anti-Consumptive Association, bids fair to be carried on with vigour and success, and soon catching spitters will probably become as remunerative a form of sport in New York as motor-trapping is to the police in Surrey.

Oxygen and Sport.

DR. LEONARD HILL is certainly interesting the world by his advocacy of oxygen, and his lecture at the London Institution last week has attracted much notice. Dr. Hill

finds that oxygen has a wonderful effect on athletes, especially those who are not in training. He got two men to box the other day, one a novice and the other an old hand. At the end of two rounds the novice was winded, so that his opponent could, if he desired, walk round him; a draught of oxygen was then administered, and forthwith the staying powers of the tyro were wonderfully increased. "There is no doubt," said the lecturer, "that the taking of oxygen before an athletic event would result in the breaking of records. We have tried it in hockey and football teams, and in every case oxygen has had a good effect." This may be good physiology, but it is bad sport. The object of a game is to test the natural prowess and staying power of the individual man, not to test the value of artificial aids to those of inferior physique. And we are not sure that it is even good physiology, for who is to say that the habit of taking oxygen for athletic contests might not lead to irritation of the bronchi, and even dilatation of the heart from the increase of unnatural strain? The use of oxygen for emergencies, such as to aid those descending into mines when explosions have occurred, or for firemen entering burning houses, is legitimate and praiseworthy, but let us have our athletic contests, at least, oxygen-barred.

Compensatory
"Phlebitis."

Surely the nadir of absurdity in workmen's compensation claims was plumbed at Cardiff the other day, when a carpenter sued his employers in the County Court for illness re-

sulting from a flea-bite. The case was brought in all seriousness, and a dramatic touch was lent by the solicitor for the plaintiff asking for an adjournment on account of his client's state of health preventing him from appearing in Court. This plea, it is true, was somewhat discounted by the fact that a man told his Honour directly the adjournment was granted that he had seen the claimant in Court that morning, and when the case came on again later neither solicitor nor client put in an appearance. Nevertheless, the case was opened and pursued up to a certain point with the usual forensic vigour, but even the gravity of the judge was not proof against the tomfoolery of the proceedings. His Honour naturally wanted to know how it was to be proved that the flea did not perpetrate the

assault in the stilly watches of the night, and, equally naturally, no proof was forthcoming. After the collapse of this case landladies who let seaside lodgings may breathe again, for if it had been held that a flea-bite was a tort, surely the gains of the occupation of many of them would rapidly disappear. There is, nevertheless, a serious side to a claim of this type. It is grossly unfair that an employer should have to bear the expense of defending himself in such an action—expense which, of course, he will never be able to recover from the claimant.

# LEADING ARTICLES.

THE EARLY TREATMENT OF INSANITY.

ONE of the less satisfactory features of the scientific treatment of mental diseases is the comparatively small proportion of cures effected under the best modern conditions. In dealing with this class of maladies, experience impresses upon our minds forcibly the unerring wisdom of the old saw which tells us that "prevention is better than cure." Indirectly, a vast amount of insanity could undoubtedly be prevented by the lessening of such common and potent causes as alcohol and syphilis. In that direction the general physician is capable of diverting from the asylums a fairly full stream of potential insanity. His achievements of that kind, however, from the nature of the case, cannot be tabulated and put on record. It is only when we turn to incipient mental disease that we are able to gauge with any approach to accuracy the effects of systematic diagnosis and treatment. In this respect, the foundation of a Mental Hospital in London marks a most important departure in a difficult and, in many ways, obscure branch of medical research. The undertaking is fully noted in the Nineteenth Annual Report of the Asylums Committee of the London County Council. It will be remembered that in February, 1908, Dr. Henry Maudsley offered the County Council a contribution of £30,000 towards the cost of the erection and equipment in London of a hospital of 100 beds for the treatment of cases of recent and acute mental disorder. This generous offer was accepted by the Council, which has caused plans to be prepared, and is now looking out for a suitable site for such a hospital. The prospect of such an addition to the machinery, so to speak, of scientific medicine will be hailed with satisfaction by all who are interested in that most important branch of intellectual activity. pointed out by the chairman of the Asylums Committee, the most forcible argument for the provision of the proposed institution, from the patient's point of view, is the fact that it will provide opportunity for individual treatment and close personal attention, which are all important in the early stages of mental disturbances. At the present time there is little opportunity for the effectual classification of patients in the wards of the asylums, where the population consists to a preponderating extent of patients whose mental condition is ohronic, and who are therefore dealt with collectively. Patients of that class call for detention rather than for treatment, as their cases are for the most part hopeless as regards cure. In Dr. Maudsley's hospital, on the other hand, only those patients will be detained for whom treatment is necessary and who respond to it. Chronic cases will not be received, or only for a brief period of detention, in order to ascertain the fitness or otherwise of the individual patient for ordinary asylum treatment. The pith of the matter is well put in the following passage from the above-mentioned Report:—There will be in the hospital an entirely different atmosphere from that of the ordinary asylum, an atmosphere, as Dr. Maudsley expressed it, of sanity as opposed to one of insanity. The hospital will be essentially an institution for providing treatment, the direct object of which will be the cure and discharge of the patient." Other valuable possibilities are opened up by the foundation of an institution of this kind in the heart of London. There will be, for instance the possible association with the scheme of various physicians and surgeons distinguished in the particular branch of medical science immediately concerned. Then there will be the inevitable corollary of an out-patients' department, an organisation, the need of which has been recognised for many years past. Another point is the probable creation of a great central teaching organisation for those desirous of acquiring a knowledge of mental diseases. As the Council pertinently remark: - "In Berlin, Munich and other cities and towns in Germany, a psychiatrical clinic and laboratories are associated with the university, and the effect has been the rapid development of clinical and pathological knowledge of mental diseases, and the proper systematic training of asylum officers, graduates and post-graduates in psychological medicine." The thanks of the public, no less than of the medical profession, are due to the London County Council for the prompt and liberal spirit in which they have accepted Dr. Maudsley's offer. From time to time we have felt it our duty to criticise that body, but on the present occasion we have nothing but praise for the way in which they are adopting a scheme that promises to confer great and lasting benefit upon the community.

# CURRENT TOPICS.

# Surgical Convalescence.

A SOMEWHAT novel appeal is being made by H.R.H. Princess Louise and some other philanthropists on behalf of a charity. They have been instrumental, with others, in starting a small home at Eastleigh for surgical convalescents, where patients with wounds requiring dressing and care are received. In most convalescent homes such cases are not received, and none need more the benefits of country air and surroundings. The proposal has now been made to extend the sphere of usefulness of this work by establishing within twenty or thirty miles of London a permanent home whither patients could be taken by motor ambulance. An opportunity has recently offered for securing a house and grounds admirably suited for the purpose, and within easy reach of London. But the committee are bound by their trust deed not to purchase until they have a funded income which will enable them to meet the necessary ex-

penses. A considerable amount has already been obtained, but it is calculated that a total sum of £30,000, producing from £900 to £1,200 per annum, will be required to put the attempt on a safe footing for providing 21 beds, which will accommodate an average of 200 patients yearly. We do not know quite how so large a number is to be accommodated at so small a price, but that is a matter for the committee; what we do recognise, however, is that this is a genuine reform in the usual way of providing for the wants of the sick. The usual method is to plunge into debt and then appeal to the public to wipe it off, and this unbusinesslike procedure has done much to discredit hospital finance and hospital methods. The present scheme is as creditable to the head as it is to the heart, and it has the backing of the King himself and seven of the leading London hospitals. We wish it the success it so well merits.

# Advertising Methods.

EVERY medical man is pestered every day by circulars of all sorts and conditions advertising goods which vary in kind from good drugs to bad cigarettes, and only a waste-paper basket as capacious as that of the editor's of a halfpenny morning journal stands between him and-let us say-golf-language. We have little objection to the straightforward firms who put their names on the outside of the envelopes, or the moneylenders who mark their communications "private," because each saves the recipient the trouble of undoing the envelope. Within a few years of appearance on the Medical Register, the doctor developes a new reflex in the deltoid, which acts immediately the envelope is brought within the visual field, and casts the irritating missive into the waste-paper basket before the brain has received the message from the eve. It becomes the business, therefore, of traders who would overcome this automatonism to devise methods for deceiving the old medical hand, and a certain firm of wine merchants, to which we will not give the benefit of a gratis advertisment, have lately achieved a certain success in this line. The plan adopted is to send a bogus letter, signed merely by a Christian name, bearing the outward verisimilitude of a genuine communication which has gone astray. Relying on the scientific curiosity of the reader, they feel sure that a letter thus worded will be sure of perusal, and we gather that their confidence is, in the majority of instances, justified. These pushful people mark their list in two prices, one for the public and one for the medical profession, no doubt trusting that the apparent bargains will be jumped at by the unwary. We have no knowledge of the stuff advertised, but if medical men have no better reason for prescribing wine than that it is represented to them that they will receive preferential rates in buying it for their own table, we have little doubt that they will prefer to recommend a sound local firm which does not resort to these artifices.

# "Reform" at Bermondsey.

The recent issue of the Local Government Board Order with regard to unsound food and foreign meat has imposed fresh and responsible duties on

such local authorities as are connected with the importation and distribution of these articles of dietary. Among others is the Borough Council of Bermondsey, through whose district passes from 25 to 30 per cent, of the imported food of London. A proposal was recently made that three additional sanitary inspectors should be appointed to carry out the new duties, and vigorous opposition was offered by the "Reformers," whose idea of reform seems to originate and end in saving of the rates. One councillor declared that soon the borough would have as many sanitary officials as inhabitants, and he suggested that if they had a little less sanitary science and a little more common sense in the administration of local affairs, it would be very much better for the health and good of the people and the convenience of the inhabitants. Fortunately the proposal was carried, in spite of the lamentations of gentlemen of this cirrhotic kidney, but outbursts of this kind tend to show how difficult is the work of real reform. The almost complete absence of food inspection has long been a crying scandal, and England, which is supposed to lead the way in most sanitary matters, is far behind most countries in this question. The addition of three modestly-salaried inspectors to deal with the food passed through a borough with the enormous river frontage of Bermondsey is surely the minimum of what might be expected in the way of discharging the responsibilities incurred in its trade in the food of the masses.

The Pathology of the Common Cold. The pathology of the "common cold" ought to be one of the most obvious of our pathological teachings, if abundance of opportunity of studying it was sufficient. Nothing is so irritating to the ordinary man as to be laid up temporarily by so trifling a cause, and one for which apparently so little can be done. An interesting contribution to the pathology of nasal catarrh appeared towards the end of last year in a contemporary. The writer, Dr. D. W. Allen, considers he has placed the bacteriology of colds on a sounder footing, and has shown how the causal organism may be recognised from the symptoms. He also thinks he has demonstrated the value of vaccine therapeutics, not only in shortening attacks, but in permanently curing chronic cases. There are five classes of organisms, one or more of which are to be found in the throat in cases of common cold. Dr. Allen states that the micrococcus catarrhalis and the bacillus septus affect the fauces and pharnyx first, and that the former also affects the trachea in company with the micrococcus paratetragenus. The symptoms are only severe in cases in which the bacillus influenzæ septus affects the fauces and pharnyx first, and that the former also affects the trachea in company with the micrococcus paratetragenus. The symptoms are only severe in cases in which the bacillus influenzæ is present. Chronic nasal catarrh is nearly always found to be due to infection with the bacillus of Friedländer. Dr. Allen records one most successful case of vaccine therapy. A friend of his who always suffered from colds after a railway journey was given an injection of 275,000,000 dead organisms shortly before starting on one. Despite

a very long and cold night journey, for the first time for years he developed neither sore throat nor nasal catarrh, nor during the succeeding twelve months has he developed a cold at all. If every one who suffers from cold could get such easy and permanent relief, we should hear less of anti-vivisectionist objections to serum and vaccine remedies.

#### Sweating by the Post-Office.

It has come to our knowledge recently that the Post Office is still endeavouring to obtain medical attendance for its employees at scandalously inadequate rates of remuneration. The rate usually offered is one of 8s. 6d. a head per annum for all employees in the district who have wages amounting to less than £150 a year. In addition to medical attendance on the Post Office servant and supplying him with medicines, the surgeon is expected to furnish half-yearly reports on the sanitary condition of the various post-offices in his district, and perform several other onerous duties, without any additional fee. For attendance on "itinerant" servants a fee of 2s. 6d. per consultation is granted, to cover advice and medicine, but no sum greater than 8s. 6d. is to be paid for attendance on any one patient in one year. In a populous city it is possible that these fees might remunerate a man to some extent for his work, but in a scattered country district, where perhaps only three or four persons are employed, the services required would not be adequately paid for at five times that sum. In addition, it is to be remembered that many of the employees, earning from two to three pounds a week, are quite well able to pay for medical attendance. We trust medical men, to whom these posts are offered, will refuse them. Unanimity on the part of the profession is all-powerful in obtaining just reward for honest services, but so long as men are willing to accept starvation wages, so long starvation wages will be offered.

# Gratuitous Health Lectures.

WE publish in another column certain resolutions passed by the County Fermanagh Branch of the Irish Medical Association, protesting against the performance of so much gratuitous work by medical men in the health campaign at present being conducted in Ireland. It is quite truly pointed out that it is the duty of the State to provide instruction for the public in matters relating to public health, and that as long as the State is relieved of this burden by voluntary effort, it is not likely practically to recognise its responsibilities. The Women's Health Association of Ireland is doing excellent work throughout the country, but the greater part of this work is performed gratuitously by medical men. We are loth to say that medical men should stand out from such work, or refuse their aid, but it is unreasonable to expect that professional work, requiring large scientific knowledge, is to continue indefinitely to be given for nothing. These philanthropic societies must carry their independence a little further, and not remain satisfied to depend on the good-will and free labour of one class of the community. If medical men were properly remunerated for the lectures given under such organisations, then all

temptation to exploit their own work or skill would be removed; and we have had regretfully to remark on one or two occasions that lecturers had succumbed to this temptation.

# The Appointment of Lady Medical Residents.

Social Manchester has recently been rent into factions by the burning question of the appointment of lady house surgeons. This, that and the other reason have been given both for and against, but in matters of this complexion it is often hard to surmise the real inwardness of things. The lady medical has clearly come to stay, but so far she has certainly not proved an unqualified success as a hospital resident officer. The fact appears to be that she shares with the rest of her sex the inherited incapacity for responsible administration, which sits easily enough on the shoulders of any man who is worth his salt. Be the explanation what it may, the average lady resident drifts into hostilities with the administrative staff as readily as a duckling takes to the water. The experience is unfortunate, and is likely to be extremely harmful to the future education of the lady doctor. If she be wise in time, she will take steps to warn all aspirants to resident hospital posts of the difficulies inseparable from the position, but all of them, we are happy to believe, to be overcome by the exercise of common tact, prudence, and forbearance.

# PERSONAL.

THE KING has sent a letter to Mrs. Cox, wife of Mr. Harry W. Cox, the X-ray scientist, who recently had practically the whole of his right hand amputated as a result of X-ray dermatitis, asking that his deep sympathy may be conveyed to her "poor husband," of whose affliction His Majesty has heard with great sorrow. Mr. Cox is progressing as well as can be expected, though he is still very weak.

THE PRINCE AND PRINCESS OF WALES paid a surprise visit to St. Mary's Hospital, Paddington, on February 8th. The Prince and Princess inspected nearly all the wards in the old hospital, and conversed with almost every patient. They also visited the new operating theatre and the empty wards of the Clarence wing, which their Royal Highnesses greatly regretted to see were still unoccupied.

THE PRINCESS OF WALES will, on February 22nd, open the new ward for children at the Great Northern Central Hospital, Holloway, and receive purses containing subscriptions towards the cost of construction and equipment.

Dr. H. Herd, of Pendleton, has been appointed a Medical Officer in connection with the inspection of Manchester school children.

Dr. J. A. Haran, Medical Officer of the East Africa Protectorate, has been appointed Medical Officer of Health for Mombasa.

MR. SINCLAIR WHITE, F.R.C.S., Surgeon to the Royal Infirmary, Sheffield, has been elected a corresponding member of the Surgical Society of Paris.

THE LORD PRESIDENT OF THE COUNCIL has appointed the Hon. Mrs. Charles Egerton to be a member of the Central Midwives Board in the place of Miss Jane Wilson, recently resigned.

THE many English friends of Dr. Schuman Leclercq (Carlsbad, Austria) will hear with pleasure that he has been made Chevalier of the French Légion d'Honneur.

On February 18th, Dr. E. Graham Little will read a paper on "The Treatment of Skin Diseases by Ionisation," and Dr. F. S. Langmead one on "Infant Feeding with Undiluted Citrated Milk," at the Harveian Society.

DR. PROUT, C.M.G., and Professor Newstead, both of the Liverpool School of Tropical Medicine, arrived at Bristol on February 10th, on the completion of a tour of investigation in Jamaica.

HIS EXCELLENCY THE LORD LIEUTENANT OF IRELAND, the Earl of Aberdeen, has accepted the invitation of the President and Fellows of the Royal College of Surgeons in Ireland to the annual college dinner on Saturday, February 20th.

THE Annual Oration before the Hunterian Society was delivered by Dr. W. Rawes on February 10th at the London Institution, Finsbury Circus. The title of his address was "Psychiatry: A Retrospect."

LIEUT.-COLONEL J. W. T. GILBERT, V.D., Royal Army Medical Corps (Territorial), has received His Majesty's permission to accept and wear the silver medal of the Order of Orange-Nassau, conferred upon him by the Queen of the Netherlands.

PRINCIPAL SIR DONALD MACALISTER, K.C.B., M.D., Glasgow University, was the guest of the Edinburgh Royal Medical Society at the President's dinner in the Society's Hall, Melbourne Place, Edinburgh, on February 9th. The Senior President, Dr. W. Kelman McDonald, presided.

At the Royal Sanitary Institute, on Wednesday, March 3rd, a discussion will take place on "The Control of Infectious Diseases in Schools." It will be opened by D. A. Carruthers, M.D., D.P.H., County Education Medical Officer, Bucks.

DR. CHARLES EDWARD BEEVOR, F.R.C.P., of Harley Street, W., President of the Neurological Society, who died on December 5th, aged 54, left estate of the gross value of £41,439 16s. 2d., of which the net personalty has been sworn at £41,037 10s. 1d.

Dr. WILLIAM ALFRED ELLISTON, of Scothorne House, Felixstowe, Suffolk, a past President of the British Medical Association and of the Medical Defence Union of Great Britain, who died on November 27th, aged 68, left estate valued at £21,407 gross, with net personalty £11,349.

WE regret to learn that Dr. Vacher, medical officer for Cheshire, has tendered his resignation to the County Council. Dr. Vacher was the first medical officer appointed by the County Council. In accepting his resignation the Public Health Committee of the Council have placed on record their appreciation of the valuable services he has rendered to the county. A special committee has been appointed to arrange the duties and fix the salary, not exceeding £750 per annum, of the next medical officer.

# A CLINICAL LECTURE

ON

# MENINGEAL HÆMORRHAGE..

By PROF. H. CHAUFFARD, M.D.,

Physician to the Paris Hospitals.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

MENINGEAL hæmorrhage is much more frequent than is generally supposed. Froin, in his thesis (1903), collected twenty-seven cases of the kind admitted during a single year in two medical wards at the Cochin Hospital. Recourse to lumbar puncture, with the escape of a reddish fluid, has enabled us to establish the frequency of a lesion which most authors of text-books dismiss with a few general remarks.

The lesion is not only very common, but it often occurs in comparatively young persons. It does not, like cerebral hæmorrhage, wait for advanced age to declare itself, since it is met with at eighteen

or twenty years of age.

We may distinguish two varieties of meningeal hæmorrhage: (1) Cerebro-meningeal hæmorrhage, in which the extravasation of blood, commencing in the brain substance, subsequently spreads by diffusion into the meninges and the sub-arachnoid space; (2) meningo-cerebral or pure meningeal hæmor-rhage, in which the blood comes from a damaged meningeal arteriole, giving rise to slight pressure on the subjacent cerebral matter. Among his twenty-seven cases, Froin records thirteen instances of cerebro-meningeal and fourteen of pure meningeal hæmorrhage. As a matter of fact, cases of cerebral hæmorrhage are in most instances meningeal as well. The blood in cerebral hæmorrhage passes into the sub-arachnoid space, as shown by the pinkiness of the fluid withdrawn by lumbar puncture; indeed, we are thus enabled to distinguish between cerebral hæmorrhage and softening of the brain. In the latter the cerebro-spinal fluid remains clear and colourless. From the point of view of prognosis, cerebro-meningeal hæmor-rhage is necessarily of graver import than pure meningeal hæmorrhage, since it is indicative of a copious escape of blood, and is accompanied by extensive symptoms of paralysis, when, indeed, it does not entail immediate death.

Pure meningeal hæmorrhage not infrequently gives rise to temporary paralyses, and the prog-

nosis is not necessarily very serious.

This man, æt. 36, suffering from a lesion of this kind, has just recovered his health, or, rather, we may say, there only remains some mental disturbance with a tendency to fixity of ideas, all the other symptoms having cleared up. In 1903 he had sunstroke, after which his temper underwent a change. In 1904 he had an attack of acute articular rheumatism which left some damage of the encephalic vessels. Then, too, he was ethylic, drinking on an average six pints of wine a day. All these circumstances predisposed him to meningeal hæmorrhage. No syphilis.

On February 6th, after a little shivering and headache, he suddenly lost consciousness. He came to, was very excited and became delirious, then passed into a state of extreme prostration. He lay curled up in bed and for some hours there was conjugate deviation of the head and eyes, in addition to which he had symptoms of slight left facial hemiparesis and stiffness of the neck. Kernig's sign was well marked, the patellar reflexes were exaggerated, and he had ankle clonus on the

left side. Babinski's sign was not well marked, and its existence could not be affirmed. There was lateral nystagmus with inequality of the pupils, loss of reflex of contraction to light, slowing of the pulse, which went down to forty a minute. Percussion of the cranium was painful over the right parieto-temporal region, and it is worthy of note that this spot is often tender in cases of meningeal hæmorrhage.

It turned out to be a case of this kind. Lumbar puncture gave issue to fluid, under pressure, of a dirty pink colour, containing 92,000 red and 4,000 white corpuscles per cubic millimetre. There were, in addition, numerous giant cells and red cells (hæmato-macrophage cells). Examination of the fundus showed peri-papillary ædema with swelling of the veins and arterial ischæmia. All these signs cleared up in the course of a few days except the headache and neck stiffness, which lasted for some time longer.

Some days later, however, the headache and vomiting of green matter returned and the torpor became marked. The patient evidently had a recurrence of the bleeding, and on lumbar puncture the number of red corpuscles had increased. This was only a matter of a few hours, after which he again began to get better. All that remains is a tendency to obsessional ideas, as evidenced by his incressent demand for his wife and children.

incessant demand for his wife and children.

There are two other clinical signs to be noted: slowness of the pulse and, now and then, a slight rise of temperature. His pulse had fallen to 50 per minute, this being no doubt due to irritation of the medullary pneumogastric centre. In view of the fact that the injection of atropine determines tachycardia by stimulation of the paralysis of the vagus, we tried the effect of injecting a 200th of a grain of this alkaloid, but it had no effect. A second injection, this time of 100th of a grain, caused the pulse-rate to rise from 50 to 78, and this acceleration lasted until the following day. The second interesting clinical sign is the rise of temperature which is occasionally met with in these patients. The temperature goes up to 990 or 99.50 F., but this should not lead us to suspect a superadded infection. In cases of copious hæmorrhage the destruction of red corpuscles is the cause of the rise of temperature, which is practically an aseptic fever. In this case no such thermometric tendency was observed, the hæmorrhage no doubt being too small.

All the symptoms had cleared up in about a fortnight, but, as I have already noted, there only remains some intellectual torpor. He understands what is said to him, and reads and writes, but only when enjoined thereto by us, for he would not do anything of the kind of his own initiative. The treatment consisted in the application of ice to the head and lumbar puncture repeated every other day, each time withdrawing some 10 or 15 cubic centimetres of fluid.

The diagnosis of meningeal hæmorrhage is based on several categories of symptoms. In the first place, lumbar puncture gives issue to a pink fluid which establishes the nature of the affection at once,

and for a certainty. Then there are the meningeal symptoms: pain, headache, stiffness of the neck, Kernig's sign, slowness of the pulse, hemiparesis and vomiting. All these signs are common to tuberculous meningitis and cerebro-spinal meningitis, but the onset is quite different. In meningeal hæmorrhage there is an initial ictus, and, apart from exceptional cases of epidemic apoplectiform meningitis, this ictus is wanting. Moreover, symptoms of infection are usual in cerebro-spinal meningitis: herpes, septicæmic eruptions, nephritis, arthritis and endo and pericarditis. None of these symptoms are met with in association with meningeal hæmorrhage, which is an aseptic process.

Some of the symptoms are compatible with an erroneous interpretation, such as the headache, which may simulate uræmic headache. Then, too, meningeal hæmorrhage is very apt to attack elderly persons, the victims of arterio-sclerosis, or who are suffering from interstitial nephritis, and, as they may also be albuminuric, we may remain in doubt for the time being. I can recall the case of a private patient who had had an ictus followed by intense headache. There was a history of syphilis, and his urine contained albumin. It might have been cerebral syphilis or uræmia. The question The question arose whether to prescribe an anti-syphilitic treatment. Lumbar puncture gave exit to a pink fluid, so that it was a case of meningeal hæmorrhage, and the treatment had to be directed to the nephrosclerous condition, and not to the syphilis.

The presence of glycosuria sometimes renders the

diagnosis difficult. I remember the case of a patient who was admitted to hospital in a state of coma. His urine contained sugar, but there was no acetonic odour of the breath, nor was the breathing sighing. The temperature, moreover, was slightly raised. Lumbar puncture showed that the glycosuria was secondary to meningeal hæmor-rhage, and, as a matter of fact, the sugar had disappeared from the urine within a few hours.

In other cases we get some paresis with facial paralysis, visual disturbances, and limited pain on percussion over the cranium, which may throw

light on the nature of the lesion.

The prognosis, as I have pointed out, is vastly graver in cerebral-meningeal hæmorrhage. Meningeal hæmorrhage is much more likely to be recovered from (three deaths in thirteen cases). In fatal cases it is often very difficult to discover whence the blood has come, so copious is the bleeding.

The distant future of these patients is, on the whole, favourable. A woman who was attacked in June, 1903, by meningeal hæmorrhage, with extremely intense headache, general contractures and left hemiparesis, was all right again in a month, with the exception of moderate exaggeration of the patellar reflexes. She came back to the hospital in February, 1908, complaining of headache, with weakness of the right arm. She dreaded a return of her previous troubles, but in reality the symptoms were due to hysteria. Lumbar puncture revealed nothing abnormal, and the symptoms cleared up in the course of the next few days.

In another case the patient was seized with mental disturbances, showing that we must make certain reservations. She was 65 years of age, and on February 21st, 1907, she suddenly became comatose On lumbar puncture the fluid was coloured; there was some fever during the next few days (99.5° F.), with slight contracture of the In the course of a fortnight she was lower limbs. doing well, but then the mental disturbances supervened: delirium, visual hallucinations and restlessness. She got up and ran about the ward, depositing her motions on the floor, sheets, &c. The lumbar fluid was clear. She was sent to an asylum

for the insane where general enfeebleness of the intellectual faculties was noted.

The present patient, as I have mentioned, also remains in a state of mental conubilation, and the tension of the cerebro-spinal fluid is still high. Possibly the intellectual torpor, to which attention has been called, is due to cerebral compression, secondary to this exaggerated intra-cerebral pres-

In the matter of treatment we must studiously avoid giving hot baths, a reason for distinguishing clearly between this lesion and cerebro-spinal meningitis, in which hot baths constitute an important factor in the treatment.

We practice lumbar puncture every two or three days, withdrawing from 10 to 15 cubic centimetres of fluid. The patient is kept in a state of absolute cerebral repose, with ice to the head, dry cupping down the vertebral column, and is put on milk diet. This sums up the treatment, but if the headache becomes intolerable, certain analgesics, such as phenacetine, will be useful in affording a measure of relief.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Prof. James Alexander Lindsay, M.D., F.R.C.P.Lond, Professor of Medicine, Queen's College, Bel-fast. Subject: "Uncommon Types of Common Diseases."

# ORIGINAL PAPERS.

SOME PRACTICAL POINTS IN THE TREATMENT OF INDIGESTION IN INFANTS. (a)

By ERIC PRITCHARD, M.A., M.D.Oxon, M.R.C.P.Lond.,

Assistant Physician to the Queen's Hospital for Children, &c.

Dr. Pritchard explained that the milk of all species of mammals was designed to develop the form of stomach that was required by the offspring. Thus mare's milk was a thin, digestible fluid which coagulated in a gelatinous clot which could pass rapidly and immediately through the pyloric opening without further digestion. These characters in the milk favoured the development in the foal of a small, functionally inactive stomach, and threw the strain of digestion on the intestines. In the adult horse the volume of the stomach represented only 8 to 9 per cent. of the whole alimentary canal; in fact, the stomach could only contain about onethird of a full meal, hence the necessity for the rapid transit of food through this organ.

In the cow the stomach was enormous, and, from a functional point of view, most active. volume it represented about 60 per cent. of the whole alimentary canal. Hence it was important that in the calf the incidence of digestion should fall on the stomach. Cow's milk was admirably designed to achieve this object; it coagulated in the stomach in a heavy, bulky olot, and required considerable digestion before it could pass through

the narrow pyloric opening.

In many respects human digestion stood midway between that of the horse and that of the cow; the volume of the stomach was about 20 per cent. of the entire digestive tract. The pylorus was not so open as in the horse, nor so well guarded as in the cow. Food remained, or should remain, in the stomach a short time as compared to the period required by the cow, and a long time as compared to that required by the horse. Human milk, owing

<sup>(</sup>a) Paper read before the Chelsea Clinical Society, January 19th, 1909.

to its physical and chemical characteristics, developed digestive powers of the kind required. It was, however, interesting to note that the training or development of the stomach was very beautifully graduated by means of colostrum. Colostrum did not coagulate in the stomach, neither did it contain milk sugar which could undergo lactic acid fermentation. Thus in the new-born infant there were no elements in its natural food to lead to dilatation or premature development of the gastric

The transition from incoagulable albumens to coagulable caseinogen was slow and gradual, and the same was true of the transition from dextrose to milk sugar or lactose. An appreciation of these provisions of Nature would explain why gastric digestion was so frequently disturbed in infants by the administration of unmodified cow's milk, which was designed to develop a large and dilated stomach.

In those cases in which artificial feeding was adopted from the first it was of the utmost importance that only those varieties of food should be administered which did not coagulate in the stomach, and which did not readily undergo acid fermentation or stimulate acid secretion. Perhaps the best form of food was whey, fortified with an emulsion of butter or some other convenient form of fat. The introduction of coagulable varieties of proteid, such as the caseinogen of cow's milk, must be carefully graduated, and follow on Nature's

Dr. Pritchard then proceeded to explain some of the points in the rational treatment of the symptoms of vomiting, diarrhoea, colic and constipation. In vomiting, he remarked that it was important

to distinguish whether the symptom was due to over-stimulation or over-filling of the stomach, or whether it was due to the mere formation of a habit. Over-stimulation was usually due to the too rapid formation of the clot of caseinogen, or to the production of an excess of acid. Over-filling was often due to incomplete emptying and pyloric

The treatment of cases of acute diarrhoea was so simple and straightforward that he was surprised so many methods were employed. The first step was to suspend food altogether for twelve hours or longer; the second, to irrigate the colon as high up as possible with hot water enemata (the water should be of a temperature of about 103° F., and plentifully employed); the third step was to administer diffusible stimulants (brandy or ammonia) and opium by the mouth. It was quite astonishing how rapidly the symptoms disappeared if this line of treatment was adhered to.

Colic, Dr. Pritchard remarked, was generally due to dys-peristalsis, and the dys-peristalsis was often caused by local congestion, or the tearing off of small pieces of mucous membrane. The motions should always be carefully washed out and examined for little balls of rolled-up mucous membrane. From a practical point of view, the best form of treatment for colic, after the urgent symptoms had subsided, was ipecacuanha wine and elixir of papain.

The treatment of chronic constipation should not be that of aperients or laxative drugs; far the best line of management was massage, combined with large and continued doses of petroleum emulsion. Petroleum, unlike animal or vegetable oils, could not undergo decomposition in the bowel, and thus lead to toxic symptoms; it could not be absorbed, and hence it reached the lower parts of the bowel, lubricated it from end to end, and softened the motions. Persistent and methodical training in regular habits was, of course, an essential element for success.

# THE ARREST OF MAMMARY SECRETION.

BY ARTHUR J. WALLACE, M.D.,

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THE arrest of the secretion of milk may appear a trifling subject to write about, even shortly, but it is one of those little points of detail that are apt to receive scant attention. The secretion of milk is no exception to the law of supply and demand, and in many cases, when there is no demand, the secretion lessens and disappears without treatment of any kind whatsoever. But there are others in which some treatment is requisite, and the methods usually employed include restriction of fluids and diet, internal administration of saline aperients, of belladonna or atropin, and of potassium iodide; whilst locally the treatment has consisted in firmly bandaging the breasts or applying belladonna in some form. These methods are, no doubt, quite useful in the majority of cases, though even there they have their drawbacks, whilst in a minority of instances they altogether fail. Dissatisfaction with them led me some years ago to seek for some remedy that would act surely, without discomfort to the patient, and which would render superfluous local treatment of all kinds.

The starting-point was the developmental affinity of the mammary gland with the glands of the skin. What reacted on the latter would probably produce some effect on the former-the reason, of course, why belladonna and its alkaloid have been so much employed. After a little search, agaricus albus was tried in the form of the tincture. It proved to be very efficacious in the first case in which it was used, so a more extended trial was made as oppor-tunity offered. Since that time it has been given in many cases, both in hospital and in private practice, with satisfactory results in every case (one exception has occurred lately; of this more anon), so that its usefulness seems to deserve a wider recognition.

Agaricus albus (white agaric, purging agaric) receives little or no notice from text-books of materia medica. According to Martindale ("Extra Pharmacopœia," 12th ed., page 725) the dose of the powder is from 10 to 30 grains, that of the tincture from 20 to 60 minims. He states also that the drug is used in small doses to check night sweats, to control diarrhoea, and to diminish bronchial secretion. In large doses it is said to be a purgative. It is also pointed out that the agaricus albus should not be confused with the fly agaric, amanita muscaria, a homoeopathic remedy employed, I believe,

for chilblains, &c.

My experience is limited to the Tr. Agarici albi, given in doses of from 30 to 40 minims in water, thrice daily, for the purpose of arresting the secretion of milk. This arrest is brought about gradually without any unpleasant symptoms or any local mammary disturbances, and without the application of local treatment of any kind. Given in cases in which the secretion has already become well established, there occurs a steady diminution in the amount of milk, until in the course of a few days it will be found that the breasts have become soft and flaccid, and that secretion is practically at an end. At the same time the skin of the body generally becomes dry, particularly that portion adjacent to the mamma and in the axillary region.

In cases of still-birth, the drug has been commenced on the day following delivery. Sometimes no secretion of milk has occurred; in other instances small quantities of fluid ooze through the nipples for two or three days, the secretion then quietly and unostentatiously disappearing. Bandaging has been used in such cases as an additional aid, but as it appeared to be unnecessary it was discontinued, and reliance is now placed wholly on the drug.

The only instance in which the drug proved unreliable was in the case of a patient who, according to her family doctor, reacts in a most surprising and unexpected manner to most drugs. The administration of agaricus was followed in this case by vertigo, so its use was at once stopped.

Whether agaricus might be useful in galactorrhœa I cannot say, as I have no experience of its use during the actual continuance of lactation. Possible effects on the infant call for caution under such circumstances

#### ON THE

# PATHOGENY, DIFFERENTIATION, AND TREATMENT OF GOUT.

By S. A. ARANY, M.D.,

#### PATHOGENY.

ALTHOUGH gout has been known long ere the Christian era, no scientific explanation of its pathogeny was offered until Garrod's time. The first step into the mystery of the causation of gout was taken by this scientist, who, with his scanty methods, established the theory that there is an excessive formation and insufficient elimination of uric acid, accompanied by reduced alkalinity of the blood and impaired function of the kidneys in gout, which is even nowadays the starting

point of all theories.

The excessive formation of uric acid, as well as the reduced alkalinity of the blood and the impaired condition of the kidneys, have been refuted by several authors, and Klemperer (1) was successful in proving that Garrod wrongly considered the gouty blood to be overcharged with uric acid, as, according to Klemperer's investigations, it was able to dissolve an additional amount of uric acid, and he also found that the alkalinity of blood was only reduced in solitary cases. Minkowski (2) also excludes the possibility of an excessive formation of uric acid, and presumes only a retention of uric acid caused by some functional disturbance of the kidneys, which view is fully shared by v. Noorden, but which is opposed by Ebstein (3), who is in favour of an excessive formation of uric acid. So far it could not be proved which of these views is correct, but since we know that the excessive formation of uric acid is not only peculiar to gout, but is also met with in Bright's disease and leukæmia, in which, however, no gouty symptoms are traceable, it is of however, no gouty symptoms are traceable, it is of secondary importance whether the formation of uric acid is, in fact, increased. The excessive formation of uric acid in Bright's disease was already known by Garrod, but he was unable to account for it. The excessive formation of uric acid in leukæmia was investigated by several authors, and Magnus-Lewy (4) found the greatest amount of uric acid, the latter amounting to 22.6 mgr. in 100 ccm. of blood. The excessive formation of uric acid in leukæmia is either due to the decay of an increased number of leucocytes or to the accelerated process of assimilation produced by the increased number of leucocytes (v. Leube, Deutsche Klinik.), and is, in spite of the fact that its extent largely exceeds the amount of uric acid present in gout, unable to produce gouty deposits. This also proves my investiga-tions in two cases of leukæmia, in which I tried Garrod's test, and although the blood-serum contained 9.5 mgr., and 8.5 mgr. of uric acil respectively, no crystallisation of urates could be effected, whereas in cases of gouty blood no negative results were experienced.

As the presence of excessive uric acid in the blood is not enough to account for the causation of gout, the authors directed their attention to the kidneys, presuming that only a retention of uric acid caused by some kidney disorder is apt to produce gout. Lewison (5) investigated the metatarso-phalangeal joints in 42 cases of kidney disease, and found in 12 cases deposits

of urates in the joints, and granular atrophy in the kidneys, whereas in the remaining cases no deposits of urates and only other kinds of kidney disorders could be established; from which he draws the conclusion that only the granular atrophy of the kidneys is able to produce gout, and, according to his opinion, it is not absolutely necessary to find visible changes in the kidneys, as the causation of gout is only due to some functional impairment of those organs. In centrast to Lewison's cases, Minkowski mentions six cases of granular atrophy of the kidneys in which no deposits were found in the metatarso-phalangeal joints, and refers to his experience, which I also fully endorse, to the effect that he has had gouty patients a great many years under his care, but never had a single case in which there was a kidney trouble diagnosable. Ebstein (1.c) mentions two post-mortems of gouty cases with normal kidneys, which, however, does not prevent him from considering a granular kidney with no deposits in it a gouty kidney; in his opinion a certain noxiousness, as in lead poisoning and in alcohol, must also be present in gout to account for the induration of the kidneys.

However, the noxiousness to which Ebstein ascribes the induration of the kidneys may, in my opinion, be looked upon as the producer of gout itself, in favour of which theory are those cases of gout in which no renal changes are detectable. Besides, it is far from ascertained whether the renal changes, if present, are the primary lesion or are only a symptom brought on by the producer in the course of the disease, and Lewison's results are by no means conclusive, as everybody will admit that there are many pathological changes, the clinical symptoms of which never were detectable intra vilam, and, on the other hand, the clinical symptoms of many a case are not justified by

the post-mortem.

But, even if there are pathological changes in the kidneys, are we entitled to consider these organs the source of the disease? as the cases of post-mortem examinations are very advanced cases of gout, in which there are renal and other changes, as a rule; and, on the other hand, they are counter-balanced by a large number of cases with no pathological changes in the kidneys, and if we are to presume in these latter an undiagnosable kidney trouble, we should be guilty of the same mistake as the supporters of the renal diabetes, of which I made mention (6) in my treatise, "On the Pathogeny of Diabetes."

We cannot and must not acquit ourselves of the fact that certain noxiousnesses, as alcohol and lead, render the constitution more prone to gout, and if we take into consideration that these substances produce a toxic influence upon the constitution, we are justified in supposing that in cases in which such noxiousnesses are not traceable, there must be another toxin which is responsible for the causation of the disease. There is even no necessity to suppose one special toxin as the producer of the disease; the latter can possibly be brought on in one case by one toxin, and in the other research we another toxic influence. Besides, we cannot

case by another toxic influence. Besides, we cannot consider it a fail accompli that the disease which, according to present-day conception, is styled gout, is a uniform disease, and future research may prove that gout, which is known to us by its symptoms only,

is brought upon us by various influences.

How far the abuse of alcohol may be instrumental in giving rise to gout can be best judged by taking into consideration the frequency of gout in different countries. Very instructive is Rendu's (7) report, according to which gout is very rarely observed in Spain, France, Italy, Turkey, and Greece; more frequently in Germany, Denmark, Sweden, Norway, and Russia; and the most cases come in England and Holland under observation. Taking the first group of countries into consideration, we see that they are, with the exception of Turkey, wine-consuming countries; the second group is inhabited by peoples consuming partly beer, partly concentrated liquors; finally, the last group represents the greatest consumers of liquors—viz., whisky, brandy, and liqueurs. One must, therefore, arrive at the conclusion that the different kinds of alcohol act differently upon the constitution, and that wine seems to be the least detrimental in contrast to spirits, which render the constitution most

prone to gout, especially in countries like England, where, besides spirits, a great deal of meat is consumed. We must maintain this view, even in the face of Herter and Smith's (8) investigations, according to which whisky contributes less towards the increasing of uric acid than champagne, as Rosenfeld (9) has proved, beyond doubt, that alcohol greatly increases the formation of uric acid by favouring the decay of the nucleins.

It is also a very well-known fact that people who have gone through rheumatism show a certain predisposition to gout. and even if we do not concur with Duckworth's (10) view that gout and rheumatism are only branches of one and the same disease, we shall have to consider a rheumatic history a possible agent provocateur of gout.

Whether all these noxiousnesses mentioned can be regarded as the producers of the diseas: itself, or whether they only favour the action of a specific gouty toxin, must be left unanswered, but one fact holds good that the uric acid itself cannot be the producer of the

Minkowski's supposition that uric acid is, under normal conditions, combined with nuclein acid, and can only in such combination be excreted by the kidneys, is, in itself, also insufficient to explain the causation of gout, as supposing the normal blood contained the combination of uric acid, suggested by Minkowski, a special influence would be required to change the normal combination of uric acid into an abnormal one.

Still less comprehensible is Ebstein's theory without the supposition of a gouty toxin; this author is of the opinion that the primary lesion is the faulty condition of the protoplasm and of the nucleus of the cell, owing to which uric acid, as well as other aloxur and nuclein bodies are formed excessively, and perhaps on the wrong place. Under normal conditions, the uric acid found in the muscles and bone-marrow is loosely combined with alkali, a part of which is being decomposed ere leaving the system, and the other part gets eliminated by the action of the kidneys. Now, if there is an excessive formation of uric acid in those organs and a hindrance to the decomposition and elimination thereof, gouty symptoms will ensue.

If we confront the individual theories of Minkowski and Ebstein we find, not taking into account that the first is not, and the latter is, in favour of an excessive formation of uric acid, a contrast between the two, as Minkowski supposes, a decomposition of the normal combination, whereas Ebstein is in favour of an insufficient decomposition of uric acid in gout. Nevertheless, both theories may lay claim to plausibility if we consider them as brought on by the influence of a toxin which in the one case transforms the soluble combination of uric acid into a combination which is not soluble in the blood; and in the other case the toxin may be regarded as the destroyer of the substance which is instrumental in decomposing the uric acid.

My presumption is confirmed by v. Noorden, who does not exclude the possibility that besides the uric acid a special toxin may be instrumental in prducing gout, and he adds that it is very likely that the uric acid is only formed in the diseased tissues, and owing to the chemical peculiarity of the process it cannot get dissolved and eliminated.

However, Ebstein himself is not quite certain whether he should entirely ascribe the production of gout to the uric acid or to an unknown poison, which may assist the former in its action.

Without the assumption of a toxin it would also be impossible to comprehend Ebstein's theory about the causation of tophi, according to which the inflammation and necrosis of the tissues precede the deposits of urates, and, therefore, we are justified in supposing that the former may be brought on by the toxin, and in the same way must be produced those gouty inflammations with no or very little deposits, and we shall have to regard the uric acid as the product of the gouty toxin, which in the course of the disease gives rise to various pathological changes of the

What kind of toxin could be blamed for the causation of gout is a question which must be left open, although a toxin of bacterial origin analogous to that of gonorrheal arthritis may come into consideration, but, on the other hand, there is nothing to prevent usfrom supposing a toxin of endogenous origin produced by the system itself to be the producer of gout.

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Even if we ignore the origin of the toxin, we are entitled to suppose that it chiefly affects the assimilation of the nucleins by either increasing the formation and changing the chemical combination of uric acid, or by changing the combination of uric acid only. The toxin also seems to possess the ability of producing inflammatory processes in the various organs in which, as a matter of course, urates get deposited.

my innamiatory processes in the various organs in which, as a matter of course, urates get deposited. The theory of a gouty toxin does not exclude heredity, which is recognised by every author, and I have to repeat here the same said (12) about the heredity of diabetes, viz., that the disease as such cannot be inherited, it is only a certain predisposition for gout, which can be transmitted from parent to child. Nor does the theory of a toxin interfere with other ætiological factors as high living, lack of bodily exercise, abuse of alcohol, and certain occupations which can possibly render the system more prone to the influence of the toxin.

As we have seen, one part of the authors does not exclude the possibility of a toxin, but at the same time-they seem to recoil from their own presumptions, trying to substitute the same partly by the abnormal condition of the protoplasm, partly by some undiagnosable kidney disease. As long as the greatest masters of research will be haunted by the idea of an undiagnosable kidney trouble, and as long as gout will not be considered from a bacterio-chemical point of view, it will not be possible to ascertain the producer of gout, and only research in the before-mentioned direction has a prospect of success

DIFFERENTIATION.

The various authors proposed, according to their individual theories, different classifications. In my opinion gout can be classified in two directions—viz., according to the origin of the uric acid and according

to the clinical symptoms of the disease.

In order to explain the differentiation in the first-named direction, we have to consider Fischer's (13) and Miescher's (14) investigations, according to which the human system possesses the ability of forming uric acid of the pre-formed purin-bodies of the food ingested, which purins originate from a combination of nuclein-acid and the albumens contained by the nucleus, chemically styled nucleo-proteils. On the other hand the system also possesses the ability of forming uric acid by the breaking down of its own bodily cells, which process is styled by Burian and Schur (15) as the endogenous formation of uric acid in contrast to the former process, which is called the exogenous formation of uric acid.

Now everybody who had a great number of gouty patients under his care will admit that there are certain cases in which a purin-free diet will not only improve the uric acid condition of the blood, but will also prevent future attacks. On the other hand, cases must be mentioned in which the withdrawal of purins, and even the severest restriction of nitrogenous food, does not produce any appreciable improvement, and Minkowski calls attention to the fact that, under certain conditions, the comparative ratio between uric acid and urea can become much lower if the restriction of nitrogenous food is too severe, than on an unrestricted diet, which is due to the fact that the severe restriction increases the breaking down of bodily tissue—i.e., the formation of uric acid.

According to the origin of uric acid I therefore propose to classify gout into—(1) exogenous or alimentary form of gout, and (2) endogenous gout.

Garrod and his followers distinguished, according

Garrod and his followers distinguished, according to the clinical symptoms, two kinds of gout—(1) the regular or articular gout, and (2) the irregular or internal gout, which distinction is, in my opinion, quite unjustified, as we have no right to consider the gout of the internal organs as irregular, in contrast to the articular gout; moreover, both kinds can be regarded as regular or irregular, as a disease which attacks the

whole system does not produce its anatomical changes according to rules.

Riess (16) calls the articular gout the acute form, in distinction from the internal gout, which he terms as chronic, retrograde, or metastatic gout. It is hardly necessary to point out how erroneous this distinction is, as everybody must be away of the fact that both kinds may be acute and chronic.

Embodying his own theory, Ebstein (l.c.) distinguishes the primary articular gout from the primary renal gout, and, as we have seen in the pathogeny, Ebstein's theory is far from proved, and therefore it cannot serve as a starting-point for the differentiation

of gout.

Taking the clinical symptoms of gout into consideration, I propose the following differentiation:—(1) The articular gout, showing symptoms of a more or less localised character; and (2) universal gout with or without articular symptoms.

The universal gout is usually the later stage of articular gout, but it may also attack individuals, who never had localised articular gout, and is apt to attack any organ without necessarily producing articular

symptoms.

Dealing with gout, I consider it opportune to mention a series of cases of my observation in which gout and nephrolithiasis, and vice versa, were combined. I feel the more justified in doing so as a number of authors claim that there is no connection between the Trousseau was the first who pointed out that the above ailments are one and the same disease, and only attack different parts of the body, and, according to either theory of gout, it is quite doubtless that the urolithiasis is only a kind of gout. In favour of this speak Hubbard's (17) reports to the effect that gouty kidney produces the same kind of nephralgia as is experienced in nephrolithiasis, and very satisfactory is the explanation offered by Minkowski, who considers the deposits of urates in the kidney the starting-point of a renal calculus, which, if liberated, gives rise to nephrolithiasis. Highly conclusive are also my own observations to the effect that 22 cases of typical gout were accompanied by nephrolithiasis, the latter being proved by gravel and calculi of various sizes; and then I have to report 18 cases of nephrolithiasis in which either typical joint-attacks or tophi were observed, the 18 cases of nephrolithiasis being one-third, and the 22 cases of gout about one-fifth of my cases of nephrolithiasis and gout respectively.
TREATMENT.

It goes without saying that an ailment for the pathogeny of which so manifold and contradictory explanations are offered, cannot have a uniform therapy, and as the healing factors suggested by the various authors are more than legion, it would be waste of time and space to consider them all. We shall, therefore, confine ourselves to healing methods the efficacy of which is objectively proved, or which are recommended by empiricism founded on huge experience, and shall start with

shall, therefore, connie ourselves to healing methods the efficacy of which is objectively proved, or which are recommended by empiricism founded on huge experience, and shall start with

The Dictary.—In the cases which I style the exogenous or alimentary form of gout, the dietary is the only healing factor to be considered, and it will be our duty to exclude all purin-containing food from the diet. Various researches, and especially those of Weintrand (18), have proved it that the nucleary organ—e.g., thymus, liver, spleen, and brain—greatly increase the formation of uric acid, and can be regarded as the chief producers of exogenous uric acid. Besides these organs, animal food in general is looked upon as a uric acid-increasing factor, and we know by Strauss's (19) researches that it is chiefly the extractive principles of meat which contribute towards the formation of uric acid, which fact may be utilised dietetically. It is a well-known fact that meat loses more of its extractive principles by boiling than by roasting, and therefore boiled meat will do the gouty patient less harm than roasted, whereas the soup in which the meat was boiled is unfit for the consumption of a gouty individual.

It has been extensively discussed whether the different kinds of meat act differently upon the formation of uric acid, and Kaufmann and Mohr (20) endeavoured to decide this question by experimenting with the different kinds of meat, and found that beef, veal, and fish equally contribute towards the formation of uric acid. Although it is not my intention to diminish the scientific importance of these experiments, I cannot help saying that, according to my own experience, gouty patients do much better if their meat supply consists of the so-called white meats. This experience of mine may also be due to the fact that the latter kinds of meat are more easily digested than the black meat, but, even if it were so, I think the preference ought to be given to the white meat, as the digestive organs of gouty patients are, in the majority of cases, also affected. Mention must also be made that the last-named authors found that eggs do not increase the formation of uric acid, which is, taking into account the high nutritive value and extensive use of eggs, of the utmost importance.

Fat, especially in the shape of butter, is recom-mended by Ebstein as a useful addition to the food, as, according to his experiments, doses of 120 grammes per diem do not increase the uric acid. He also recom-mends to substitute the carbo-hydrates by fats, as the former give rise to indigestion. I personally cannot concur in Ebstein's opinion, and think that the exclusion of carbohydrates in preference to fat-stuffs is more likely to cause indigestion. This I know by my vast experience in diabetic cases, and although Minkowski's argument in favour of Ebstein's prohibition is that no food-stuff is so easily misused as the carbohydrates. I cannot see my way to withdraw this purin-free food from gouty patients. On the other hand, there is no doubt that an excess of carbohydrates may also be instrumental in doing harm, but it is our duty to prevent the patient from excesses of any kind, and to give him just the amount of calories required by his system. Therefore, I should never think of giving a patient more or less than 35 calories per each kilo of bodily weight (excepting the acute attack of gout), and even Ebstein admits that anything producing a weakening effect upon the constitution is apt to do the patient

Even the fact that we have to restrict the consumption of meat is an indication not to deprive the gouty of the carbohydrates, and the easily digestible green vegetables, salads, potatoes, and the indispensable bread, are very welcome additions to the diet, whereas the cereals, the dry leguminosæ, cucumber, tomato, and sweets can easily be dispensed with.

The noxiousness of alcohol has already been pointed out, and the gouty subject is best advised to abstain from alcohol in general. However, not in every case shall we be successful in attaining total abstinence. Besides, there are also cases in which the total restriction of alcohol is contra-indicated, in which cases we shall have to allow a pint of light wine, well diluted with mineral water, or one to two glasses of Pilsen beer per diem. English practitioners permit a small amount of old whisky, with plenty of water, which is, according to Herter and Smith's investigations, less detrimental than champagne. Our view about spirits las been pointed out in the pathogeny, and we only want to add that, owing to the greater concentration of alcohol, spirits are more easily taken in excess than any other kind of alcohol, and are, therefore, best prohibited.

Among the other popular drinks, coffee and tea have to be considered, the first of which, although its noxiousness has so far not been proved, I usually exclude from the diet, as my experience has taught me that the clinical symptoms of gout are detrimentally influenced by coffee. Weak tea and cocoa seem not to interfere with gout, but the most suitable beverage for gouty people is undoubtedly milk, which I also (23) employ as the only article of food during the acute attack of gout, in spite of Cantani's (22) apprehensions that the lactic acid contained by the milk is apt to reduce the alkalinity of the blood, which neither Cantani nor others were successful to prove. As far as the products of milk are concerned, butter has already been mentioned, and, with regard to cheese, we usually avail ourselves of different kinds of cream cheese in preference to strong cheese. The latter, as well as spices, spiced sauces, and preserved food, are unsuitable for gouty subjects, and I was told by many a sufferer that, according to his own experience, the hors d'œuvre and the dessert are the chief sources of his attacks.

Last, but not least, we have to bespeak the water, which may be freely consumed by the patient, and if there are no contra-indications on the part of the circulatory organs and the kidneys, it will be advisable for the patient to take large quantities of water so as to effect a washing-out of the system. This purpose is served best by the alkaline table waters— $\epsilon.g.$ , the Biliner and Giesshübler waters.

Having considered all the articles of food, it only remains to make practical use of them, and in so doing we must consider one fact—viz., that moderation in every respect has to be the chief feature of the gouty patient's diet. We shall not recommend him more than three meals daily, and shall give him for breakfast a cup of weak tea or cocoa, or a pint of milk, two eggs, and bread and butter; his dinner will consist of soup (with the exception of broth and beef tea), 200 grammes of meat or fish (preferably boiled), green vegetables, stewed fruit, a light and not sweet farinaceous dish, cheese, fruit, and half-a-pint of light wine, with plenty of water. The evening meal, which must not be taken too late, may consist of 100 grammes of ham or cold fowl, eggs in every shape, to which one may add plenty of vegetables, cheese, bread and butter, and fruit, and, as a change, porridge or rice may also be made use of.

Whether dietary has any influence on the formation of endogenous uric acid has not been decided satisfactorily, but, as dietetic measures certainly improve the clinical symptoms of gout, we are not wrong in supposing that a suitable diet is also apt to reduce the

formation of endogenous uric acid.

The Medicinal Treatment refers to a great extent to the acute attack of gout, and is, in spite of the fact that latterly quite a number of "uric acid dissolving, combining, or eliminating" drugs have been recommended, by no means more advanced than twenty years ago, as all of these specifics of gout have failed to prove their specific action, and one feels compelled to return to the older drugs. Amongst these we gladly avail ourselves of the iodide of potassium, or of its newer and less disagreeable substitute, the sajodin, of which drugs one usually prescribes from 2 to 3 grammes per diem. Very effective are the salicylates, and especially the aspirin and its varieties, the nov- and diaspirin and salol, which increase to a large extent the elimination of uric acid. In what way this is performed is not established, but, in my opinion, it is very likely that it is the antiseptic action of the salicylic acid contained by these preparations to which the improvement is ascribable. The same refers to the good results obtained by urotropin, in which drug the antiseptic action of its chief component, the formaldehyd, has to be considered. In cases of long duration it will be advisable to use the drugs so far mentioned alternatively, and it will be quite safe to prescribe from 3 to 4 grammes per diem of any of them. In very painful cases we may add small doses of antipyrin. phenacetin, or pyramidon, or still smaller doses of opiates to the salicylates, but it is advisable not to be too generous with the former.

English doctors have a decided liking for colchicum, although the salicylates exceed its action by far, and do not prove so frequently detrimental to the heart as the former.

The alkalies deserve special consideration, and although their action upon the gouty system is far from ascertained, the authors gladly take refuge in them if all the other drugs have failed. Most popular are the natural alkaline mineral waters containing the various kinds of alkali in judicious concentrations, which renders them most convenient for the purpose. The purgative action of these waters is also of great importance, and whether their temperature does not produce special osmotic changes is a question which has to be considered. In the case of the Carlsbad waters we shall also have to consider their radioactivity, which is, as we know, a healing factor of great importance.

It is also customary to prescribe baths in gout, and for this purpose warm baths are recommended in preference to cold ones, as the latter are not well tolerated by the patient. The same refers to excessively hot baths, which also prove detrimental to the ailment, whereas for local applications both cold and hot com-presses can be considered.

Of the greatest importance is bodily exercise, which is, excepting the acute attack of gout, when the patient is best confined to bed for a few days, just as important a part of the treatment as the dietary and medication. There is no doubt that walking is the best kind of exercise, but also the various sports, if connected with walking, may answer the purpose.

- 1. Klemperer: "Lösung und Zerstörung der Harusäure im Blute Gesunder und Gichtkranker." Therapie der Gegenwart. 2. Minkowski: "Die Gicht.' Nothnagel's "Pathologie und Therapie."
  - herapie."
    3. Ebstein: "Die Gicht." Deutsche Klimik.
    4. Magnus-Lewy: "Der Stoffwechsel der acute und chronischen
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# OPERATING THEATRES.

GUY'S HOSPITAL.

INTERSTITIAL HERNIA. - MR. R. P. ROWLANDS operated on a stout publican, who had worn a truss for double inguinal hernia for many years. He attended a public dinner three days before operation. Soon afterwards several of his companions were seized with abdominal pain and vomiting, but the patient remained well until the next morning, when he had diarrhoea. The bowels were opened three times in quick succession, and each time the ruptures came down and were as frequently replaced by the patient himself without unusual difficulty. The right one was not seen afterwards, although the left descended several times when the truss was off. Upon returning from business in the evening, the patient was taken with shivering, vomiting, and collapse. The vomiting persisting, Dr. Jaynes was called in. At first the pain was general all over the abdomen, but towards the evening it became localised to the right iliac region, where a tender region, where a tender swelling appeared and rapidly increased in size. The vomiting continued, and the bowels were not moved after the next morning, although a good deal of flatus was passed. The temperature was raised, and the pulse became increasingly quick. On the third day after the seizure Mr. Powlands saw, the potient in consultation with Mr. Rowlands saw the patient in consultation with Dr. Jaynes. At that time the abdomen was distended, but fairly supple, except on the right side, where it was rigid and tender. A large oval swelling occupied the appendicular region, its long axis passing downwards and inwards nearly as far as the middle of Poupart's ligament. This swelling was resonant in front, but dull at the side; it fluctuated and gave a succussion splash; it seemed to be too prominent for an appendicular abscess, containing gas. Rectal examination revealed nothing more than some bulging due to increased abdominal pressure. An enema was given, without result. A little fluid was discovered in the right hernial sac, which was within the scrotum. The

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE. CLINICAL SECTION.

MEETING HELD FRIDAY, FEBRUARY 12TH, 1909.

The President, Sir Thomas Barlow, Bart., K.C.V.O., in the Chair.

Mr. Butlin exhibited his collection of drawings of EARLY CARCINOMA OF THE TONGUE and of conditions which may be mistaken for it; and spoke of the results of the operations which had been practised in the cases exhibited. Microscopical sections of the cases were on view. He said that recently the *British Medical Journal* had published for him a series of 197 operations for cancer of the tongue. Since then he had had 3 more, bringing his total up to 200. Another journal, commenting upon this paper, had said that this number seemed so small, and that other surgeons must have performed very many more. Mr. Butlin contested this, and said that as far as he could determine no Continental or American surgeon whitehead was the only surgeon who had operated upon more cases than himself. Dr. Tatham, from the Registrar-General's Office, had informed him that 5,253 persons died from cancer of the tongue from the control of the control of the tongue from the control of t 1901 to 1907, makin gan annual average of 750. Allowing generously for recoveries as the result of treatment, this meant that probably about 820 persons suffer in England every year from this disease. The bad prognosis, in operations for this disease, had drawn his attention to the importance of early diagnosis, and treatment, so that he had at one time described a precancerous stage, but had found great difficulty in getting operations, both from the patient and his doctor, while he himself was unable to declare decidedly that cancer was present. Five years ago he had sent to Dr. Bashford material from a "precancerous" condition, which had proved to be well-marked carcinoma. Afterwards he had had careful drawings made of all such cases, and had insisted upon operation. From this collection he could separate five classes of early cancer of the tongue:—(1) A little plaque, like a hard sore, smooth and polished, but neither ulcerated nor excoriated. (2) The transformation or replacement of a simple ulcer by a cancerous ulcer, which only differs from the simple ulcer by feeling a very little stiffer and firmer. (3) The transformation of an entire plaque of leucoplakia into a plaque of cancer. The dif-ference was marked by a very slight thickening, a denser white, and furrowing or fissuring in various directions, but without excoriation or ulceration. The transformation of one small area of leucoplakia into cancer, only marked at first by very slight super-ficial hardness. (5) A white warty growth or com-pound wart, not ulcerated, feeling as if it were fixed in the mucous membrane and quite superficial. These were the most frequent and typical varieties, but there were other less distinct forms.

Since he had had drawings made of these early stages, and had insisted upon operation, he had operated upon 14 cases, 12 of which were drawn. 3 had died-i of nephritis and cardiac failure, but without recurrence; r, four years later, from secondary affection of glands, 1 for which early operation had been refused. Eleven were alive and well, at periods of from 8 months to 41 years. No local recurrence developed in any of the 14 cases, although 8 had lived for from 3 to more than 4 years after the operation. The glands had been removed in 9 of the cases. The diagrams exhibited showed that the extent of the operation was generally out of proportion to the size of the cancer, but this was to remove the leucoplakia and chronic superficial glossitis.

There was one other point to which he would like to draw attention. "The air was charged with emanations of radium," which had been positively stated to cure early epithelioma of the tongue. Until recently, if he had been asked, he would have said that those who were best able to judge would have concurred in

patient was moved to Guy's Hospital, where an operation was performed by Mr. Rowlands without delay. Just before the operation the patient was rather col-Under general anæsthesia an oblique incision was made over the prominence of the swelling, the fibres of the external oblique were separated, and the cæcum was at once exposed extra-peritoneally. It was greatly distended with gas and some liquid fæces. Towards the inner part of the incision the hernial sac Towards the inner part of the incision the nermal sac was discovered and opened. Sanious fluid escaped, and the cæcum and appendix were seen to be congested and streaked with yellowish lymph. The obstruction was due to kinking of the cæcum upon the ascending colon at the neck of the hernial sac. At this point the cæcum had turned abruptly upwards and outwards round the lower border of the internal oblique muscle, upon the outer surface of which it The flexion was maintained by the pressure of the external oblique, which seemed to act almost like a strap. After drawing the cæcum downward and incising the lower border of the conjoined tendon, the hernia was then reduced and gas and pus escaped from the general peritoneal cavity, and lymph was seen upon the ascending colon and upon the ileum. A hand was therefore passed into the abdomen to seek a possible further cause of the peritonitis. The stomach, duodenum, gall-bladder, and pancreas were normal. It was therefore concluded that the peritonitis was due to the inflamed condition of the strangulated gut, and that leakage had occurred into the peritoneum through the wide neck of sac. The peritonitis seemed more or less limited to the right flank. The neck of the hernial sac was closed except for an interval for a large tube containing a wick of gauze. The lower part of the sac was drawn up from the scrotum and removed.

Mr. Rowlands said there was considerable difficulty in the diagnosis between appendicitis with a gascontaining abscess and reduction en masse of a right inguinal hernia. The absence of complete constipation as regards flatus, the unusual size and resonance of the swelling, and absence of history of pain or difficulty in reduction of the hernia, were much against reduction en masse. The swelling seemed to be unusually prominent and soft for a gas-containing appendicular abscess, but the general symptoms, the pyrexia, the early diarrhœa, and the later constipation, seemed to support this diagnosis. The presence of fluid in to support this diagnosis. The presence of fluid in the scrotal sac could easily be accounted for by either hypothesis, if the reduction en masse were considered to be due to laceration and not displacement of the sac. Interstitial hernia was, unfortunately, not thought The condition found at the operation was one of abrupt kinking of the ascending colon round the lower border of the conjoined tendon. There was no strangulation at the neck of the sac. The peritonitis was no doubt due to infection through the wall of the damaged bowel. It was difficult, he considered, to explain how the non-peritoneal part of the cæcum came to be in the sac; it was probable that the rupture had never been completely reducible, but that the cæcum had always been present in the interstitial part of the sac, to which it was congenitally adherent posteriorly.

In spite of active treatment by means of copious infusions of saline solution, and subcutaneous injections of ernutin, mx. every four hours, the patient gradually sank, and died two days after the operation. The bowels had acted several times. The post-mortem revealed hypostatic pneumonia and fibroid hypertrophied heart. There was localised peritonitis and a good deal of congestion of the lower part of the ileum and cæcum, but there was no perforation and no

Or the four general hospitals proposed for the London Territorial Force, the 1st, commanded by Lieut. Colonel H. M. Ramsay, F.R.C.S., is to be mustered this year for its first training at the Cambridge Hospital, Aldershot, and the 2nd, under Surgeon-Colonel C. Godson, at the Herbert Hospital, Woolwich. No arrangement has been made for the training of the 3rd and 4th London Hospitals, which, unlike the 1st and 2nd, have not yet attained the position of being officially recognised as units of the Territorial Force.

stating that there was no evidence to prove that radium was able to cure lingual cancer, and he would have added that the only case under his care so treated has ended disastrously. But, within the last few days, he had seen a case in which a typical epithelioma of the inside of the cheek had so much improved that it looked as though it would be quite cured. Radium, however, must act very differently from any therapeutic measure we at present understood, if it not only cured locally, but followed and eradicated the disease from the glands and intervening channels.

Mr. A. E. BARKER congratulated Mr. Butlin on his successful results. He had himself devoted attention to the pre-cancerous stage, and, when in doubt, had always extirpated the portions of the tongue affected. In only one case had cancer not been present. He hoped that the paper would stimulate all to increased activity in dealing with early suspected cases. He was not so sure that removal of the glands was always necessary, for undoubtedly many cases had recovered in which this had not been done. There were cases of very great and others of very low malignancy, and it was probable that some of the great successes were due to the fact that the surgeon was dealing with cases of low malignancy.

Mr. WALTER SPENCER thought that the small-celled infiltration which runs down between the muscle fibres should be taken as evidence of malignancy, and should indicate early removal of glands. Therefore the patch should be completely excised, and a microscopical examination made, before deciding on removal of the glands.

Mr. CLUTTON said that he was in absolute sympathy with all Mr. Butlin had said, both with regard to the removal of the growth and of the glands.

Mr. Bowlby had always removed the lymphatic glands, in all cases, with one exception. The patient had been unwilling in this case, and although that was eight years ago, there was at present no recurrence. He regarded this, however, as the exception rather than the rule. He had seen the patient referred to by Mr. Butlin as treated successfully by radium, but had not thought the case one of malignant disease.

Dr. Bashford said that one of the first discoveries that the Imperial Cancer Research workers had made, was that a very small piece of growth, even to the size of a pin's head, or less, could, by engrafting, reproduce all the evidences of cancerous growths, including metastases. He regarded Mr. Butlin's work as one of the first-fruits of the investigation. The growth was often spread out in a fan-shaped manner in the deeper structures, and this indicated a wider range of operation than apeared on the surface. New growth was modified by various constitutional changes, and these might take place suddenly and favour sudden dissemination. There was no means of telling how a tumour would behave from its intrinsic biological characters or from any constitutional symptoms which may arise.

Mr. Butlin, in reply, admitted that cases occurred which did not lead to metastases, but said that there was no method of distinguishing them, so that he did not consider it ever safe to leave the glands. He referred to a meeting of the Harveian Society, 25 years ago, at which the late Mitchell Banks had urged removal of the axillary glands in mammary cancer. This was now generally accepted, and he thought that the same would be true of the glands in cases of cancer of the tongue.

Dr. H. Morley Fletcher showed four cases of Oxycephaly.

CASE 1.—Male, æt. 21, assistant store-keeper; condition dated from early infancy. Intelligence good; vault of skull pointed; sagittal suture felt as a thickened ridge. Extreme proptosis; strabismus; globe of right eye was recently dislocated forwards as the result of a slight blow; patient was able to replace it under the lids himself. Mr. Holmes Spicer's report on the eyes: "Vision (with glasses) R.=6/36, L. sees only moving objects. Fundi: nerve fibres confined to upper and inner part of the opening in the sclerotic, probably due to an imperfect closure of the fætal cleft. The nerve fibres are also very pale, presumably due to primary atrophy. Both conditions more marked in the left eye." Defective formation of superior

maxilla; arch of palate extremely high; apex only just wide enough to admit tip of finger. Upper Jaw shortened; second and third molars absent on both sides, present in lower jaw. Antra practically non-existent. Naso-pharynx small in all dimensions (the deflection of the nose to the left is the result of an accident many years ago). His mother has proptosis and malformation of superior maxilla to a less degree, but her vision is good, and the cranial vault is of natural shape.

CASE 2.—Boy, æt. 13, Hebrew, very intelligent. Frequent headaches. Skull oxycephalic. Eyes: marked exophthalmos; left, external strabismus, nystagmus. Vision: could distinguish large objects. Fundi: double optic atrophy. Deformity of superior maxilla not so marked as in Case 1.

CASE 3.—Female, æt. 41, charwoman, intelligent, subject to occipital headache all her life. Skull oxycephalic. Proptosis and slight nystagmus. Vision: blind in left eye as long as she could remember; there was useful vision in right eye. Double optic atrophy.

The hard palate was asymmetrical and narrow. Case 4.—Boy, æt. 11. First child; breech presentation. Probably this case was closely related to the foregoing, but the characteristic shape of the vault of the skull was not present to the same degree. There was proptosis, but no nystagmus. Vision: R.=6/6, L.=6/9. No optic atrophy. The upper jaw was small and ill-developed.

He said that this rare deformity of the skull, otherwise known as "tower" or "steeple" head (lhürmkoff), generally came under the notice of ophthalmic surgeons, on account of the defective vision associated with the condition, and a large proportion of the recorded cases have been described in the transactions of ophthalmological societies. The cases exhibited the characteristic abnormally-shaped cranium, exophthalmos due to imperfect formation of the orbits, impairment of vision, the result of partial or complete optic atrophy, and varying degrees of malformation of the superior maxilla. There was no obvious defect of intelligence in any of the cases shown.

Dr. SUTHERLAND said that in some cases he had seen there had been a degree of mental defect.

The PRESIDENT said that the cases evidently came under the order described by Virchow as due to premature union of the cranial bones in various positions. The association of optic atrophy, he thought, a new point and one of special interest, and he would like to know how this was produced; was it by local overgrowth of bone pressing on the optic nerve?

Dr. Morley Fletcher, in reply, said that the condition was due to synostosis of the basis cranii and malformation of the superior maxillæ in his cases. The optic atrophy was certainly primary, and was probably due either to nipping of the optic nerve in the optic foramen, or to twisting of its course from maldevelopment of the basis cranii. All the cases of which he knew had shown a normal mental development

Mr. P. MAYNARD HEATH showed a case of DIFFUSE PERIOSTITIS OF BOTH TIBLE WITHOUT OTHER EVIDENCE OF CONGENITAL SYPHILIS.

Male, æt. 5, was brought with the complaint that his knees had been knocking together for three months, and that his shins had been swollen for one month. On examination, a slight degree of genu valgum was found. The skin of the front of the legs was slightly edematous and tender, and the superficial veins were dilated. There was a diffuse sub-periosteal thickening involving the length of the shaft of both tibiæ, most marked in the middle of the shaft and more on the right side than the left. There were no other signs of disease. The boy was one of a family of eight children, one of whom was under treatment for a tuberculous affection of the face at a London hospital, and another had been treated for a tuberculous knee at a provincial hospital (see next case); the others are The mother had not had any miscarriages, healthy. and no history of rashes, sore throat, or loss of hair could be obtained. X-rays showed diffuse deposit of new bone under the periosteum of both tibiz. As the result of treatment with mercury and potassium

iodide, the tenderness and cedema of the legs had disappeared.

Mr. P. MAYNARD HEATH also showed a case of CONGENITAL SYPHILITIC KNEE.

Male, æt. 3, brother of the previous patient, had suffered from a bad knee for twelve months, and had been treated for tuberculous disease of the joint with-Examination revealed some degree of left genu valgum, and that the inner side of the kneejoint was swollen and hot, the swelling lying chiefly over the inner tuberosity of the tibia. The synovial membrane felt thickened, there were a slight effusion in the joint, and some wasting of the thigh muscles. The bridge of the nose was broad and flat, but the boy did not have snuffles in infancy.

Dr. PARKES WEBER showed a case of CONGENITAL SPLENOMEGALY WITH CHRONIC ACHOLURIC

JAUNDICE.

The patient was a well-developed boy, æt. 14, somewhat anæmic and slightly icteroid. The spleen was evenly enlarged and hard, reaching to the anterior superior iliac spine. The liver could not be felt, and apparently was not enlarged; faces were not acholic. The urine was generally of rather low specific gravity, clear, pale, and free from albumin, sugar, and bile-pigment, but sometimes showed excess of urobilin. The blood serum was found to contain bile pigment, and when examined during the boy's most normal periods, showed a few normablasts and slight polychromatophilia. A blood-count on November 6th, 1908, gave 2,800,000 red cells, and 14,280 white cells to the cubic millimetre; the differential count of white cells gave lymphocytes, 20.6; intermediates, 4.8; large hyalines, 4.4; polymorphonuclears, 68.4; eosinophils, 1.0; mast-cells, 0.8 (no nucleated red cells seen on that occasion). A later blood-count (January 21st, 1909), gave 3,140,000 red cells and 14,500 white cells; hæmoglobin, 70 per cent. The resistance of the red cells towards hæmolysis had been tested on various occasions by Ribierre's method, and it is found that hæmolysis occurred when a few drops of the patient's blood, diluted with normal saline solution, were added to a solution of between 0.40 and 0.48 parts per cent. of sodium chloride in distilled water. There did not, therefore, appear to be much evidence that the chronic acholuric jaundice is "hæmolytic" in the present case, at all events, the evidence that it was due to congenital fragility of red cells was insufficient. Mr. Dudgeon found that the patient's blood-serum had no auto-hæmolytic action; nor had blood-serum from a normal individual any hæmolytic action on the patient's red cells.

The history was that he was born at full term with the help of instruments, and was very yellow at birth. The jaundice never completely disappeared; his eyes (sclerotics) had always presented a slight yellowish tinge, but his complexion had generally been sallow rather than distinctly yellow. He had been always subject, however, to recurrent attacks of "depression," during which his urine became darker and he appeared yellower, and he suffered from lassitude and drowsiness. These attacks occurred about every three months and lasted a few days. Sometimes he suffered from severe abdominal pain. He had never had any form of hæmorrhage, excepting a mild attack of purpura in 1899, when he was 4 or 5 years old, at which time the blood contained many nucleated red cells. His spleen was apparently first noticed to be large when he was 3 months old. He had always been subject to nocturnal enuresis. He had had no other illnesses ex-

cept "croup" at 1 year of age.

There was no probability of a congenital syphilitic taint. A sister, the twelfth of a family of thirteen, with anæmia and splenomegaly without any jaundice, died at the age of 1 year and eight months. Both she and the patient were shown in 1905, by Dr. Porter Parkinson, at the Society for the Study of Disease in A most interesting point was that the mother said that all her children were born yellow and remained yellow for three to six months after birth, but the jaundice was permanent in the present patient only.

Mr. R. HIGHAM COOPER showed a case of ADVANCED ACROMEGALY.

The patient, a man, æt. 51, stated that the enlargement of his extremities was first noticed in the great toes 17 years ago. His hands had always been unusually large. Changes in the ears and nose had begun 13 years ago, and the condition had steadily advanced. The size of the cranium was normal; there was enormous enlargement of the nose, ears, eyebrows, and upper eyelids, the latter hanging over the eyes so as to cause considerable limitation of the field of vision. He stated that he could not see out of his right eye, but the ophthalmoscope did not show any abnormality except slight pallor of the disc and blurring of the cup; there was no retinitis or hemianopsia. The malar bones were very prominent, but the superior maxillæ and upper teeth seemed normal; the mandible was prolonged forward so that the lower teeth were fully half an inch in front of the upper. The lower teeth were separated from one another by small intervals. Tongue was large, reddish, and furrowed with hypertrophied papillæ. There was enormous bulbous enlargement of the fingers, but the bones were free from the characteristic deformities. There was some general hypertrophy, but little change of texture or of their due proportion, and from the radiographic point of view they presented the typical characters of advanced gout; all the fingers showing deposits on the shafts of the phalanges, several with well-marked spurs, and one finger had two distinct excavations in the base of one phalanx and the head of the next. In the feet there was an entirely different picture; there was backward dislocation of most of the toes, and all the phalanges, except the terminals, had pipe-stem shafts with enormous "cauliflower-like" proliferation of the heads and bases, this proliferation being of a cancellous nature. Several attempts to take skiagrams of the sella turcica had been made, but without success. Skiagrams of the rest of the body did not show any special points of interest, except a gouty condition of the knees.

Mr. R. J. GODLEE showed a patient whose

FEET WERE DEFORMED BY GONORRHOBAL RHEUMATISM. The man, æt. 54, complained of pain in various joints, but was shown to the Section on account of the deformity of both feet, apparently the result of "gonorrhœal rheumatism" 29 years ago. The feet at that time had been simply bandaged. The soles were flat, the toes in the position of hammer-toe, and the ankles could only be flexed beyond a right angle after flexing the knees. All the joints of the tarsus and the metatarso-phalangeal articulations were believed to be in a condition of bony anchylosis. The spine was stiff and probably anchylosed. There was old iritis in both eyes and choroiditis in the left eye.

Mr. W. SAMPSON HANDLEY showed a case of ELEPHANTIASIS TREATED BY LYMPHANGIOPLASTY.

The patient, a clerk, set. 46, has never been abroad. The disease began in 1895 with swelling of the left testicle and pain in the left leg. The limb was moderately swollen and presented patches of erythema. Since that time he had been subject to recurrent pyrexial attacks, accompanied by erythema of the limb, which had steadily increased in size. On admission to the Middlesex Hospital in April, 1908, the left lower limb was enormously enlarged, especially below the knee. On the posterior aspect of the calf were two Another large mass occupied the dorsum of the foot. The patella could not be felt. The skin was much thickened, coarse, and rugose. Filariæ were absent from the blood. The first attempt at lymphane set plasty failed, owing to sepsis along the threads, set up by micrococci, which were present in the lymph previous to operation. Vaccine treatment was successfully applied to exterminate the infective cocci, and the operation was repeated on October 17th, 1908. The swelling of the limb rapidly subsided; within ten days the circumference of the limb just above the ankle fell from 21% in. to 12% in.; of the calf from 25% in. to 17 in.; and of the knee from 20 in. to 16% in. The subsidence had since continued less rapidly; the tissues had become soft and flabby; the skin thin and supple. The patient had now been back at work for some weeks, and there seemed to be every prospect

that the result of the operation will be permanent. This case—the first in which Mr. Handley's operation of lymphangioplasty had been applied to disease possessed more than ordinary interest, in view of the fact that elephantiasis had hitherto been considered incurable.

Dr. HERBERT P. HAWKINS exhibited a

CASE SHOWING TROPHIC CHANGES IN HANDS AND FEET, WITH ANÆSTHESIA (PROBABLY LEPROSY).

The patient, a girl, æt. 19, was born of English parents at Perambur, about three miles from Madras. About two miles from her home there was a leper She never came in contact with native children, but a native ayah was in attendance upon her for 18 months before any sign of disease was observed. Father, mother, and other children are healthy. The early history is not clear. Her father states that in 1803, she, being then four years of age, developed a "roughness" and "scabbing" on the knuckles of both hands. A native apothecary diagnosed leprosy, and prescribed a course of Chaulmoogra oil. From that time up to the present date the disease had made slow but uninterrupted progress. She had been in England since 1900. There was no dissociation of sensation. There was no perception of touch, pain, or temperature below the elbows and below the knees. Sensation was normal over face and trunk to all forms of stimuli. There was wasting of the intrinsic muscles of both hands, otherwise muscular nutrition was maintained. Muscular power was good; knee-jerks were rather brisk; no plantar reflex, and no ankle clonus, and no spasticity. Gait was normal. Skin of hands was rough and scaly, but by rubbing in ung. syno-cardiæ she had improved their appearance. There was a small oval patch on the right shin, where the skin was devoid of pigment. The ulnar and external popliteal nerves were not obviously enlarged. There were no enlarged glands and no joint affections. The fingers of the right hand showed a slow necrosis of soft parts and bones. Where a phalanx had been lost, remains of the nail were still perceptible on the stump. The left hand was in a similar state. X-ray examination verified this account, and showed also that a swelling of the second finger of the right hand was due to periostitis. The right foot showed a large ulcer on the ball of the great toe which began as a deep-seated blister. There was a smaller ulcer on the plantar surface of the left foot. No acid-fast bacilli were present in the discharge from the ulcers on the hands, and none were obtained from the nose.

Dr. F. PARKES WEBER showed a case of

CHRONIC SWELLING OF THE FINGERS.

The patient was a well-built, slightly anæmic-looking, unmarried woman, æt. 20. She complained of a persistent swelling or hard cedema of all her fingers. This had always been more or less noticeable as long as she could remember. There was some tendency to blueness of the hands and chilblains of the fingers in cold weather; and when she let her hands hang down they tended to get very red and sometimes blue, but there was no pain as in erythromelalgia. The swelling affected the soft parts of the fingers only, as shown by Rontgen-ray photographs. Examination of the blood showed nothing beyond slight anæmia. There was nothing remarkable in the family history. The case seemed to be allied to those of so-called "acro-

Mr. R. J. GODLEE showed a case of DERMOID CYST OF THE MEDIASTINUM TREATED BY OPERATION AND ILLUSTRATED BY A PATHOLOGICAL SPECIMEN.

This was the continuation of a case presented to the Clinical Society before operation by Mr. G. E. O. Williams and Dr. Batty Shaw, on October 27th, 1905. The patient was submitted to several operations in University College Hospital. In the first of them the lower part of the cyst was exposed by the removal of costal cartilages. The upper part was in such intimate relation with the large vessels at the root of the lung that its removal was impossible. Some portions of its inner wall and large quantities of hair were taken away. On subsequent occasions other portions of the skin lining the interior were cut away and cauterised. The result had been a considerable improvement in the general health and diminution of the expectoration. But a large opening remained in which the deep part of the cyst appeared, a forcible pulsation being transmitted to it by the action of the heart. There was a certain amount of discharge consisting of mucus and sebaceous material, with a characteristic offensive smell. There had been several attacks of hæmoptysis, in some of which a considerable amount of blood had been lost. Hardly any hairs were now produced

The specimen shown was one presented to the Museum of the Royal College of Surgeons by Mr. Thomas B. Mouat. The cyst, which was on the opposite side of the chest, presented many features of resemblance to that of the living case. The lower part was intimately associated with the pericardium. The upper was embedded amongst the large vessels of the

mediastinum.

The importance of considering the specimen in connection with the case was that it is possible thus to appreciate the kind of difficulty likely to be encountered in any attempt at removal of these particular cysts, which are in all probability teratomas.

Dr. Poynton showed a case of

AMAUROTIC FAMILY IDIOCY.

Female, æt. 9 months, had been brought to the hospital because she was unable to sit up; she had a dull and heavy expression, and was apparently almost blind. She was the second child; the first died at the age of 2 years and 4 months of what was called "water on the brain," but was clearly amaurotic family idiocy. Both parents were Jews, but were not related, and enjoyed good health. At birth she was apparently a normal infant, but since the age of 1 month had been noticed to be feeble in her movements; in the second month it was difficult to attract her attention with bright objects, and since then she had been going slowly down hill.

When exhibited she was very well nourished; expression vacant; skin of face rather greasy; possibly

could see a little; smiled frequently. Pupils, equal and rather large, reacted sluggishly; the fundi were quite characteristic. The limbs were very feeble, but not spastic, and there were no deformities. knee-jerks were present and the plantar response was extensor; the muscles appeared to be very flabby. The urine did not contain albumin or sugar. The particular points of interest were: (1) The early age at which suspicion was aroused; (2) the extremely well-marked changes in the fundi; (3) superficially the healthy appearance of the infant; (4) that the diagnosis of rickets had been made, as in three other cases under observation in the last four years.

Mr. L. COLLEGGE (for Mr. W. E. Fisher) showed a

patient illustrating

SPLENIC INFARCTION—SPLENECTOMY.

A married woman, æt. 47, the subject of mitral stenosis and visceroptosis, was suddenly attacked with pain in the left hypochondrium. On admission four days later there was a large tumour on the left side of the abdomen; the diagnosis lay between splenic infarction and torsion of the spleen. Splenectomy was performed the next day; the spleen contained two large infarcts and was adherent to adjacent parts. The patient left the hospital 25 days after admission. There was no anæmia and no glandular enlargements: 14 hours after a heavy meal the leucocyte-count showed

p,600, and 5 hours after a meal, 11,322.

Dr. H. MACNAUGHTON-JONES, JUN., demonstrated A SIMPLE APPLIANCE FOR OBTAINING, AND AUTOMATICALLY MAINTAINING ANY REQUIRED PRESSURE, ABOVE OR BELOW THAT OF THE ATMOSPHERE, WITHIN ANY CLOSED CAVITY CONTAINING AIR.

The apparatus, which might be appropriately termed a static pump, could be used for such purposes as exhausting an aspirator, cupping, or applying Bier's method of treatment. He first described its use with The apparatus consisted of a Bier's cupping-glass. two bottles of similar size and shape, each provided with two openings—one in the usual situation, and the other in the side of the bottle as near the bottom as possible. The lower opening in one was connected to the corresponding opening in the other by flexible tubing, and the bottles were half-filled with water. The upper opening of one was attached by tubing to the cupping-glass, whilst the other remained free. To facilitate description the former bottle was referred to as the "chamber," and the latter as the "receiver." the receiver was raised above the chamber, the water it contained flowed into the latter, filling it, and expelling the air which occupied its upper part through the tubing connecting it to the cupping glass. On lowering the receiver below the chamber the process was reversed. By raising or lowering the receiver, the water could be made to move up and down in the chamber like a piston, alternately drawing in and expelling air through the cupping-glass. If the receiver was lowered when the chamber was full, and the entrance of air prevented by the application of the cupping-glass to the skin, as the water descended in the chamber a partial vacuum was established and its flow arrested. The degree of vacuum depended upon the fall of water; if, e.g., the surface of the water in the chamber was 14 in., 28 in., or 56 in. above that in the receiver, the pressure in the former and beneath the cupping glass would be about 1 lb., 1 lb. or 2 lb. respectively, below that of the atmosphere.

Should a little air accidentally leak in beneath the

edge of the cupping-glass, as it usually does, it would simply permit of the escape of water until its flow was arrested by the establishment of the original vacuum. Thus by regulating the height of the fluid in one vessel above that in the other, the required pressure could be obtained and automatically maintained. precaution was necessary: the orifice of the lower opening in the receiver must always be covered by fluid, otherwise the pressure might fall below (the vacuum exceed) that which was intended.

In order to exhaust an aspirating bottle it was attached to the chamber precisely as the cupping-glass was; the chamber taking the place of the airpump or syringe at present employed for exhausting. If, however, any leakage occurred around the neck of the bottle, or in its connections, its extent would be rendered evident by the continued escape of water, and the degree of vacuum would be constantly known. When it was necessary to re-establish the vacuum in

the aspirating bottle without disconnecting it, the following manipulation should be carried out:—The tube connecting the bottle was furnished with a three-way cock. This might be used so as to bring the interior of the chamber into connection with the atmosphere, while cutting off the bottle. While in this position the chamber was filled in the usual way by raising the receiver; the tap was then turned so as to close both the bottle and chamber. The receiver was then lowered and the cock turned into its third position, in which it brought the chamber and aspirating bottle into communication again, while cutting off the atmosphere.

# ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, JANUARY 29TH, 1909.

Dr. PUREFOY in the Chair.

## MODIFIED INSTRUMENTS.

Dr. Ashe demonstrated a new principle for application to Bozemann's catheter and Braun's hollow sound by means of which every part of the uterus could be dealt with without fear of undue pressure. The instrument which he exhibited allowed all the fluid to come back, and with it the uterus could be flushed It was simple and cheap, and could be absolutely sterilised.

The CHAIRMAN considered that the instrument had a wide range of utility.

The SECRETARY spoke, and Dr. Ashe replied.

ADENO-CARCINOMA OF THE VULVA.

Dr. Solomons exhibited specimens of above. said that adeno-carcinoma of the vulva was such a very rare condition he thought the case would be of interest to bring before the Section. This he was able

to do by the kind permission of Dr. Tweedy, the

Master of the Rotunda Hospital.

M. W., æt. 33, married eight years, 4-para, was admitted in November, 1908, to the Rotunda Hospital. She had noticed a lump in the vulva two weeks before admission, and this ruptured just before she entered the hospital. Pruritus was absent. Patient was blanched from loss of blood. On examination it was found that there was a large stinking mass protruding from the vulva, which seemed to spring from inside from the vulva, which seemed to spring from inside the right labium, just at Bartholin's gland. The tumour was evidently an hæmatoma. On its removal an excavated sloughing sore came into view, which had all the appearance of acute phagedena. A microscopic examination showed nothing save blood clot. The cavity was plugged with iodoform gauze. Thinking that perhaps the affection was syphilitic, the patient was given a mixture of hydrare, perchlor, and potassium iodide. Insuffation with calonel was also potassium iodide. Insufflation with calomel was also used. Two weeks later, as there were no signs of improvement, the excavated sore was opened up, scraped, curetted, and thoroughly swabbed out with iodised phenol. In spite of this treatment, combined with keeping the wound plugged with peroxide of hydogen, alternating with formalin 1 in 3, together with the antisyphilitic treatment, the phagedænic sore spread with alarming rapidity, and it became evident that a condition of malignancy probably existed: this, despite the fact that no glandular enlargement existed anywhere and the negative microscopic findings. Therefore, heroic measures were considered to be indicated, so, under an anæsthetic, the parts were explored, and the curette, knife, scissors, cautery and nitric acid were freely used in an endeavour to stay the disease, whilst large portions of the tissue that had not sloughed were removed for microscopic examination. Although the infection spread over to the other side, yet the urethra seemed in no way implicated, and lay in the midst of the disease as an isolated tube.

Their pathologist, Dr. Rowlette, reported that the case was one of adeno-carcinoma of the vulva. This diagnosis was only arrived at after he had cut a great many sections.

There were no apparent primary growths in any part of the body, and the only possible original seat of the disease seemed to be in Bartholin's gland.

The CHAIRMAN said he had an opportunity of seeing the case, and leant at first to the idea that it was a form of syphilitic disease. He was particularly struck with the absence of induration of any tissue in the neighbourhood of the disease, which he would have thought likely to be observable in malignancy.

RUPTURED EXTRA-UTERINE PREGNANCY.

Dr. FreeLand exhibited specimens from a case of the above, taken from a patient, æt. 35, who had been married fifteen years, and had had four children and four abortions. She had come to him two weeks before complaining of hæmorrhage, and menstruation overdue two weeks. On examination she was found to have retroverted uterus and a small tubal mass in the left side. He thought she had a tubal pregnancy. She would not remain in hospital; she had considerable pain when she went home. She returned the next day, and the following Tuesday he operated. On opening the abdomen he found the pelvis full of blood. The fœtus had escaped into the abdomen and was attached by the cord to the rest of the ovum in the tube. The ovary was left in position, and she had done very well.

The CHAIRMAN thought it extraordinary that the loss of blood was so inconsiderable, seeing the size of the rent in the tube, unless the rupture took place gradually.

Dr. HOLMES spoke.

DOUBLE PYOSALPINX.

Dr. FitzGibbon exhibited specimens of the above from a patient, at. 31. She had been married seven years, and had one pregnancy, which ended at term, five years before the operation in August last. She had been under observation eighteen months, and during that time very little change was seen in the pelvic condition. The uterus was normal in size, and

hard. On the right side there was a hard mass pressing down on the right fornix, and on the left side they could make out a tube thickened, but not embedded. Her menstrual periods were normal, and she was very little troubled until the last six weeks, when she developed severe pain. The abdomen when opened seemed tolerably normal until he attempted to pull up the intestines, when nothing would move, and he found the whole of Douglas's pouch filled with adherent small intestines. He got the whole of the tumour out without tying any vesels, as they had been obliterated. He closed the stump of the cervix with two interrupted sutures, and packed the pelvis with gauze. Two days after the operation the pulse went up 110, though the temperature neither then nor subsequently went above 99°. He withdrew the gauze and put in a long drainage tube. On the third day the pulse climbed gradually up to 160; the following night it fell to 140. He then put in a shorter tube. She continued to improve; but next morning he found a smell of urine. He replaced the tube with one of rubber, and concluded that the drainage tube had sloughed through the bladder. He kept the tube in although some still came away in the urine. The patient made a good recovery. The case showed the danger of hard drainage tubes put through the abdominal wall into the pelvis, and also showed how pyosalpinx, which was obviously chronic for eighteen months, could still set up an infection of the pelvis, although it was stated that if left for twelve months the pus would become sterile.

Dr. Holmes thought the absence of any menstrual history or pain was a most remarkable thing.

Dr. Jellett thought that the bladder fistula was due to an original extension of the infection to the bladder wall at the place where the two were adherent. Necrotic areas were frequently found, and there was no reason why there should not be one on the bladder muscle that gave way when it lost its support. That would account for the fistula not having formed for several days; obviously it was not made at the operation.

Dr. Gibson said he was sure the pain was sufficiently bad to indicate operation, but they had to consider whether the cure or the disease was the greater evil.

Professor Alfred Smith thought the drainage should have been through the vagina. He did not gather whether the infection was pure or mixed. He thought that streptococci alone became so attenuated in eighteen months as to be harmless.

The CHAIRMAN said he did not think there was any positive knowledge as to when infection became sterile. His own experience was that pyosalpinx might remain quiet for years, and under fresh stimulation might light up again. He was satisfied that where there was reason to believe a swelling to be a pyosalpinx, it was always a possible danger, and should be dealt with in most cases by radical operation. Most of them would be inclined to drain in the direction of the vagina; still it was surprising what effective drainage could be carried on through the aldominal wall.

Dr. FITZGIBBON, in reply, said he started with the intention of draining through the vagina, but from start to finish he did not see the bottom of Douglas's pouch, and he had not the least idea where the ureter was, and at the end of two hours' operation he drained in the easiest direction.

A SHORT CRITICISM OF THE RADICAL CURE OF BACKWARD DISPLACEMENTS OF THE UTERUS.

Dr. Jellett began by discussing the present attitude of gynæcologists towards the radical cure of backward displacements of the uterus. He considered that in all cases in which the patient's symptoms called for relief, a radical operation should be performed in preference to the prolonged use of a persary. As exceptions to this rule he mentioned puerperal displacements, as they could usually be cured by the temporary use of a pessary, and cases in which the circumstances or general health of the patient made operation inadvisable. He showed that, if a patient had to be curetted, the performance of a radical operation prolonged her stay in hospital only by a week. He divided

the different radical operations into three groups:—
(1) Cases in which a major operation has been performed, and in which the peritoneal cavity has been opened. For these cases he always concluded the major operation by performing a ventral suspension. (2) Cases in which the displacement is complicated by adnexal disease. In these cases he advised the opening of the abdomen followed by ventral suspension. Cases of uncomplicated backward displacement. these cases he unhesitatingly advised Alexander's operation on account of its safety and its after-results. He then discussed Alexander's operation, and referred to the statements of Drs. Herman and Galabin, who considered it an essentially dangerous operation. In opposition to this he quoted statistics of 385 cases, practically all of which were successful, and amongst which there was a single death from croupous pneumonia, and unconnected with the operation. His own statistics were as follows:-Forty-four cases were operated on. In 39 the usual double incisions were made, and in 5 a single incision. There were thus 83 separate incisions, and every one of these healed by primary union. One incision subsequently suppurated, owing to the fact that the subcuticular suture broke during removal and was left behind. One patient died, but her death, which was from double croupous pneumonia coming on about a week after the operation, had nothing to say to it In one case the uterus subsequently fell back, and in this case only one ligament had been shortened. The other was left, as it was difficult to find, and as the operation had been already prolonged by the preliminary steps of curetting, trachelorrhaphy, and ligature of piles. In this case the uterus was in a normal position when the patient was seen six months later, but it had fallen back when seen two years later. Two patients at least were subsequently delivered, and after delivery the uterus remained in a normal position. The speaker then stated in detail the reasons he considered Alexander's operation the operation of choice in cases of uncomplicated backward displacement of the uterus.

Professor Alfred Smith said he was against Kelly's operation, as he looked upon the suspension as wrong. He believed in the efficacy of Alexander's operation for simple backward cases. That, however, applied to a limited class of case. If Alexander's operation was used in all cases that came to them, there would not be sufficient beds for them. It was only in the better-class patients that shortening of the round ligaments would come into greatest practice. In a case which he thought an ideal one for radical operation, the uterus righted itself when he removed the pathological conditions. If he had shortened the round ligaments he would have thought that it brought about the result. He considered a modification of Bumm's operation the best.

Dr. Ashe said that even if the round ligaments were shortened they would stretch again. He believed Alexander's operation to be by far the best on physiological grounds. It was surprising how in simple cases complications were found when the abdomen was opened, and that was, he thought, a point in favour of the suspension method. He thought there might be a fear of hernia.

Dr. Holmes said the difficulty was to know when they had not got complications. An enormous number of women who came with backward displacement suffered also from sterility, and no gross lesion was found in the tubes. In 50 per cent. of cases that he had examined, the uterus had gone back after child-birth, and he found cases often get right by inserting a pessary for about two months. He thought there was still room for the pessary in gynæcology, and he did not regard any of the operations as final.

Dr. Gibson said the cases for the Alexander-Adams operation were those in which retroversion occurred after childbirth. He thought the best operation for uncomplicated cases was the Alexander, and out of six which he had examined after childbirth in only one had the uterus gone back.

Dr. FITZGIBBON said that when they were dealing with an uncomplicated case they pre-supposed that the adnexa of the uterus were healthy, and there was nothing to interfere with pregnancy and the proper

involution of the uterus after childbirth. In such cases there was a very large scope for the pessary.

Dr. MATSON said that when he was house surgeon to Mr. Alexander, he had the opportunity of seeing him operate in many cases, and at that time he said he usually placed a pessary in position for about two months after the operation.

Mr. L. G. Gunn said there was a cystoscopic method of examination of the bladder for determining to what extent the uterus had been brought forward. He had found a uterus pulled over somewhat on one side.

The CHAIRMAN recalled a case operated on by Mr. Alexander, in which there were three miscarriages afterwards. If a woman became pregnant after suspension, the peritoneal supports were rent, and there was nothing to prevent recurrence. He assumed that before operation they would see that the uterus was reduced in size. He was certain that there were many cases in which the pessary would give relief, and some in which it would effect a cure.

Dr. JELLETT, in reply, said the difference between the treatment which he advocated and the use of the pessary was a week in hospital, and he thought that was less serious than two or three years' pessary treatment, even if in some cases the pessary succeeded. Kelly's operation was not an ideal one, but it had the advantage of taking very little time to do when the abdomen was already open. So far from Alexander's operation causing a hernia, it would probably cure any inclination to hernia, as the walls of the inguinal canal were sutured and a patulous external ring was closed. Obliquity of the uterus was not, he thought, a matter of importance. In three or four cases in which he only shortened one round ligament, he had in a month or so found the uterus in the middle line. The great majority of cases were those in which the uterus had fallen back after childbirth, and in these there was no necessity to look for causes of sterility, but if there was any doubt as to the condition of the adnexs, he agreed with Dr. Holmes in opening the abdomen. In one of his cases a patient became pregnant afterwards, and had great pain from pulling on the external abdominal ring as the uterus developed. The uterus was also very large, and there was hydramnios. He feared during pregnancy that the operation was in some way responsible for this, but eventually the woman was delivered of a stillborn syphilitic infant. He thought that a similar cause probably accounted for the repeated abortions in the case recorded by Dr. Purefoy.

# CHELSEA CLINICAL SOCIETY.

MEETING HELD JANUARY 19TH, 1909.

The President, Mr A. F. PENNY, F.R.C.S.I., in the Chair.

MR. T. CRISP ENGLISH showed the following cases:—
(1) Laminectomy for paraplegia. A boiler-maker, act. 42, who had had symptoms of pressure upon the fourth dorsal segment for six months. Operation was performed in September, 1907, and a cyst attached to the root of the fourth dorsal nerve inside the membranes was removed. Recovery was rapid and complete. (2) A boy, with considerable enlargement of the spinous process of the sixth cervical vertebra; an excellent skiagram of the whole of the cervical spine by Dr. G. A. Simmons was shown. (3) A case of fracture of the humerus, with musculo-spiral paralysis. Mr. J. HOWELL EVANS presented a further report on

THE CASE OF TUMOUR OF THE JAW
in a girl, æt. 12, which was shown at the last meeting. This little patient was operated upon, an incision to the extent of 6 in. being made parallel, but, for cosmetic reasons, below the lower border of the right jaw, and the soft structures overlying the tumour reflected upwards over the face. An awl was driven through the centre of the base of the tumour, and a Gigli saw passed through the tunnel thus formed. The tumour was sawn off from its base parallel with the outer surface of the jaw without injury either to the sockets of the teeth or mucous membrane of the jaw or cheek. Further pieces were pared off. In consistency the tumour varied from that of bony hardness to the con-

sistency of (softened) fibro-cartilage. A layer of goldleaf was placed over the surface of the jaw. Microscopically the tumour presents the structures of a calcifying cardio-myxo-fibroma. Mr. Howell Evans had not yet come to a definite conclusion as to the origin of this tumour, neither could he give an assured prognosis. He was of opinion, however, that there is not sufficient evidence of malignancy to, at present, warrant resection of the mandible. (Mr. Howell Evans exhibited photographs illustrating the aspect of the patient before and after operation, X-ray photographs of tumour in situ, and tumour removed; also microscopical specimens.)

Dr. ERIC PRITCHARD read a paper on the TREATMENT OF INDIGESTION IN INFANTS, which will be found in another column, under the heading of "Original Papers."

In the discussion that followed,

Dr. WILLIAM EWART dwelt upon the intrinsic value of the paper, which was singularly luminous and lucid. The physiological standpoint adopted by Dr. Eric Pritchard in his clinical conclusions was one which could not lead to disappointment, as the lines which were to be pursued were measured upon those followed with unerring success by Nature. A question might be asked in connection with the principle advanced by Dr. Pritchard that the milk supplied went to the young in each species to educate the stomach to its specialised work in that species, how it was to be explained that milk suited to digestions so different as those of cows and of asses should both be suited for the human infant, whose digestion differed so much from both. With reference to the clinical uses of paraffin, he could entirely endorse the views which had been expressed. He had long administered paraffin in the treatment of enteritis, of colitis, and of constipation, and it entered into the treatment which he had recommended for enteric fever. In the gastrointestinal ailments of infants and of children, he made extensive use of the same remedy.

made extensive use of the same remedy.

Dr. Parkinson thought that more attention should be paid to the food and the manner in which it is given than to the art of administering drugs for the treatment of troubles which should be prevented. Children were often treated as if they were all of one type and made like so many Waterbury watches, instead of which each child was born with different powers of absorption and powers of resistance. Any physician attempting to bring up children on one stereotyped text-book rule was sure to meet with many failures. In his experience he had met with more disease and trouble from over and improper feeding than under-feeding. In a properly trained, healthy child constipation should not exist.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD IN THE FACULTY HALL, FEB. 5TH, 1909.

The President, Dr. WALKER DOWNIE, in the Chair.

DR. JAMES MACLEAN showed a little girl, in good health, who had recently suffered from a most severe and prolonged attack of

CEREBRO-SPINAL MENINGITIS.

He also exhibited the temperature chart, extending over a period of eleven months, to illustrate the extreme rapidity with which the variations occurred. The variations were very often extreme in degree also, sometimes reaching 106°, and getting as low as 98.8°. Dr. Maclean read notes of the case. When the illness began the child was 4 years and 3 months old. Stiffness and pain was complained of in the right hand in the morning. The child was restless during the day, and at 3 p.m. was thought to be dying. Its skin was livid, and petechiæ were present. The temperature was 103°, the pulse very rapid, and the skin so tender that the child could not bear to be touched. The same evening the temperature was 98.8°. Next day the head became retracted, the pupils dilated, and all the other typical symptoms were present. The screaming fits often ended in a kind of trance, when the patient lay passive for a few hours. The feeding was all forced at this time. About the fifth day pain began in the left ear, and two days later in the right

ear and in the eye. After two months there was some improvement in the child's condition. This lasted for over a week, and was followed by an exacerbation of the symptoms. A month later the symptoms were less acute, and the patient in a more passive condition. She had still the catalepsy after the screaming, and required the frequent administration of bromide of potash and antipyrine for that and for twitching squint. This condition lasted for about three months more, when the patient was considered hopeless. She was very emaciated, having been dependent on rectal feeding for nourishment for a long time. Dark hair covered the face and extensor surfaces of the limbs, and the weakness was very extreme. At the end of 61 months of illness there were signs of improvement The left arm began to move; then the right arm. Some two months later the legs could be stretched, and the improvement continued till she could take an interest in dolls and pictures. After in months the patient had recovered from every sign and symptom of the disease, and had no sequelæ, but was very weak. She is now—two months later—quite plump and strong, has no deafness or other defect, and is as alert and intelligent as the average child of her age. The interest in this case turned upon the extreme illness, the duration, and the completeness of the recovery. The feeding was also interesting as showing the large quantities of food that were sometimes taken. In the treatment, anti-meningococcous

serum was tried, but without benefit to the patient.

Mr. HENRY RUTHERFURD showed a girl, æt. 8, who

suffered from

OSSEOUS ANKYLOSIS OF THE JAW which he treated by excision of the condyle and neck of the mandible. The condition followed upon suppurative disease of the middle ear, and an operation for this had been performed on the right ear some time previously. The lower jaw was firmly fixed and could not be moved. After the excision of half an inch of bone a useful movable joint was formed, and the mouth can be widely opened and mastication carried

on with efficiency.

Mr. Henry Rutherfurd also showed two specimens of "Rupture of the Intestine," and read notes of several cases of a like nature. He endeavoured to demonstrate that in these cases the muscular coat of the bowel ruptured as the result of direct injury, and this allowed the mucous coat to become herniated through the opening thus made. After a variable period of time the mucous coat also ruptured, and the contents of the bowel escaped into the peritoneal cavity. Mr. Rutherfurd pointed out the importance of opening the abdomen as soon as possible after an injury, even when there was only symptoms of hæmorrhage, as this allows of any dangerous condition being discovered and attended to before perforation has time to occur.

Dr. KERR LOVE described a case of

PERI-SINUS ABSCESS, with mural thrombus in the sinus, basal meningitis, and tuberculous tumours in the pons, cerebellum, and both sides of the cerebrum. The child had suffered from measles and whooping-cough, and this was followed by symptoms of ear disease. There was tenderness on the right side over the masteid process, and pain behind the ear, with slight bleeding from the ear. An operation was performed. Very little pus was found, and this contained pneumococci and streptococci only. No relief resulting, another operation was performed two days later, and an abscess was found surrounding the sigmoid sinus, but no sinus thrombosis. After a few weeks' treatment the child was fairly well and went home. A month later the wound was septic, and pus was discharging from the meatus. An operation was performed, when the mastoid process and the region of the sinus was filled with granulation tissue. A month later facial paralysis came on without any apparent cause. The tip of the mastoid was removed, but the paralysis got worse. Four days later rigidity of the muscles of the neck set in, and a few days later optic neuritis developed. The temperature rose to 106°, and death ensued.

The post-mortem examination of the head showed that the ear condition was not the primary disease,

but was only an incident in a much more serious condition; and Dr. Kerr Love pointed out the importance of this in tuberculous cases, where the operation for the ear condition may do more harm than good, and

cannot remove the chief seat of the disease.

Dr. Kennedy, who made the post-mortem examination of the head, showed parts of the brain in which many tuberculous masses, about the size of peas, were found. These were situated in the pons, the cerebellum and the cerebral hemispheres. There was a basal meningitis as the result of the tubercles, and this was the cause of death.

# CORRESPONDENCE.

## FROM OUR SPECIAL CORRESPONDENTS ABROAD.

# FRANCE.

Paris, Feb. 14th, 1909.

THREE USEFUL DRUGS.

CAFFEIN, theobromin, and ergotin are three therapeutic agents of great utility as they render signal ervice in complications of various affections.

Caffein exists in green coffee in the proportion of from 3 to 6 per cent. An infusion of coffee is thus very useful in certain cases, but its abuse determines, after prolonged use, agitation, trembling, vertigo, and pal-pitations; there exists, says Prof. Carnot, even a kind of intoxication due to the immoderate use of coffee.

Caffein is also found in tea, cacao, kola, etc.

Being but little soluble in water, salicylate or benzoate of soda has to be added to increase its solubility. Its action and stimulating properties on established, while it is also an excellent diuretic. Consequently it is used as a nervine and muscular tonic in typhoid fever, grippe, fatigue, mental strain, as a cardiac tonic where the heart shows signs of failure, and as a diuretic in a certain number of cases where other agents have been tried without success.

Theobromin is a therapeutic agent of very great value and employed constantly; either before or after

digitalis; it has no cumulative effects.

Theobromin is extracted from cacao, but it has the inconvenience of being insoluble in water, and has to be given in wafers. It can, however, be dissolved in water by the aid of salicylate or acetate of soda.

Theobromin has little or no action on the heart, but on the other hand its diuretic properties are known to Many, however, have failed to derive all the benefit from this drug they had a right to expect, but chiefly because the mode of administration was at fault. Instead of prescribing ten grains three times a day, the wafers should be given every hour for three hours, intense diuresis is generally the result with an important elimination of chlorides. The addition of an equal quantity of phosphate of soda increases its activity.

Theobicmin is particularly prescribed in renal dropsy, heart affections with cedema, and in arterio-

sclerosis.

Ergotin, an excellent hæmostatic, is a vaso-constrictor of the first order affecting especially the small

It acts almost immediately after absorption, and affects principally the muscular coat of the intestine and the uterus.

It is utilised in metrorrhagia due to the presence of phthisis, myocarditis, medullary congestion. In hæmorrhage of the digestive tract it is sometimes beneficial; but in epistaxis and hemoptysis it is un-

AORTIC ANEURYSM. The treatment of aneurysm of the aorta consists chiefly in lacto-vegetarian régime, rest. and the following:

Iodide of potassium, 21 dr. Ext. of opium, 4 gr. Hydrate of chloral, 1 dr.

Water, 10 oz.
One tablespoonful before meals; to be continued until

signs of intolerance set in, when it is dropped, but continued later on.

Injections every week into the gluteal region of a solution of gelatin:

Gelatin, 30 gr. Chloride of sodium, 20 gr. Sterilised water, 7 oz.

One ounce the first week, increasing each week by five drachms until three ounces are reached.

Against oppression, 10 drops of an alcoholic solution of oxy-camphor at 50 per cent. on a piece of sugar

three or four times a day.

To lower the arterial tension, from three to six days daily a solution of trinitrin in a tablespoonful of

Inhalations of nitrite of amyl may be utilised with advantage.

In case of hæmoptysis, a tablespoonful every two hours of

Chloride of calcium, 1 dr. Syrup of opium, 1 oz. Water, 4 oz.

For the cough:

Ext. thébaïque, ½ gr.
Ext. of datura, 1-10 gr.
For one pill; two to three in the 24 hours.

When the aneurysm is of syphilitic origin, one tablespoonful twice a day of:

Biniodide of mercury, 1 gr. Iodide of potassium, 5 dr. Syrup of orange, 14 oz.

Such is the treatment recommended by Prof. Robin for aortic aneurysm.

#### GERMANY.

Berlin, Peb. 14th, 1909.

AT the Medizinische Gesellschaft, Hr. Albu discussed the subject of VISCERAL PTOSIS

as a Constitutional Anomaly. He opposed the view so widely spread that splanchnic ptosis was exclusively a disease of females; it was certainly more frequent with them, but it was not absolutely rare in men; and even in children it was to be observed often enough. The most frequent was nephroptosis. Amongst the material of his Klinik he had met with the condition in 68 per cent, of the women and in 21 per cent, of the men. The most frequent form was nephroptosis, then followed gastro- and entero-ptosis. He had also examined new-born infants, and out of 94 examined had ascertained that ptosis was present in 44 per cent. of the females, and it per cent. of the male infants. He was convinced still further by this circumstance that splanchnic ptosis was not a local affection, resulting, as was so often thought, from relaxation of intraabdominal pressure, but a symptom in part of a con-stitutional anomaly. This found its expression other-wise, as Stiller and Matthes had rightly observed, in the structure of the skeleton and the development of the soft parts. The writers named had described a habitus enteroptoticus, which was in complete agreement with that designated as the habitus phthisicus. As the typical stigma of this growth, which he designated the habitus asthenia universalis he mentioned the roth floating rib, which in the speaker's examinations was by no means always present.

A prominent feature of this habitus was the increased growth as regarded length, which was usually considerably more than the measurement of the extended arms, or of eight times the length of the head. W. A. Freund had pointed out the narrowness of the upper thoracic aperture and the importance of this as regarded the development of phthisis.

In the soft parts were to be found soft, flabby breasts, wide apart in women, general under-nourishment, flaccid abdominal walls with depression of the upper half of the abdomen, combined with fulness of the lower half.

The speaker took the enteroptotic habit for a paralytic one and a disturbance of embryonal development. It was a sign of bodily insufficiency and the result of insufficient care and exercise of the body continued through generations. By means of photo-

graphs and statues he showed that at one time artists preferred to represent men of this habit, and thought from this that at one time it was more general than at present. In the levying of recruits in later years Schwieling had reckoned that an increase of height had taken place during recent years in all the countries inquired into, a fact that was only of value when the other bodily development kept pace with it. That was not the case, however, everywhere. In Prussia fitness for military duty had slightly diminished.

From a therapeutical point of view we were powerless against visceral ptosis, we could at most render the condition latent by bandages, etc. On the other hand, we should strive to develop a healthier and stronger race by appropriate bodily hygiene, gymnastic exercises and so forth.

Hr. Lennhoff was of opinion that a deviation from a so-called normal index, as well as palpability of the kidneys, was no proof of a low bodily condition, other

things had to be taken into consideration as well.

The Deutsch Med. Zeit., February 4th, 1909, contains a communication on the

TREATMENT OF INGROWING TOE-NAIL BY PERCHLORIDE OF IRON.

The method was proposed by Prof. Rehn, and has been in use in the Städ Krankenhaus, Frankfort a/M., for the last fifteen years. It consists in the following: A little lint is wrapped round a bit of stick, and dipped into pure perchloride of iron; it is then dabbed over the inflamed overgrown soft parts, as well as over the ingrowing part of the nail. The applicaas over the ingrowing part of the nail. The applica-tion must be allowed time to sink in and work, so the lint must be kept pressed on the parts for some little time. The process can easily be made quite painless. It should be repeated in 24 hours if required. The iron dries up the parts very quickly, the wall of inflammation shrinks, becomes hard and retracted, the nail brittle, the pain vanishes. In milder cases the parts heal quickly. It is said that even phlegmonous processes disappear. Many of the cases may be treated in the out-patient department.

(No mention is made in the above of a useful little wrinkle, that is—to cut a groove down the length of the nail with a file or fine fret saw. The groove should be fairly deep, but should not, of course, reach the "quick." This makes the nail weak along that line, so that it "gives" there instead of forcing its way into the flesh.—CORR.)

# AUSTRIA.

Vlenna, Peb. 14th, 1909.

SPASMUS PALATINUS.

W. SCHLESINGER presented a man to the meeting of "Innere Medizin," who, after a severe cold a year ago, suffered from a peculiar rushing sound in the head with a strange ticking like a clock. On examining the patient no such sound could be observed by the examiner till the head was half a metre distant. Inspection of the fauces revealed a regular contrac-tion and pause in the muscles of the soft palate causing the uvula and velum to rise upwards and outwards violently, and strike against the side of the orifice.

A case of this nature, free from any other com-plication, he had not met with in the literature on the subject. The remote cause in this case he attributed to hysteria, although he confessed there was

much obscurity in the presumption.

Fuch said this reminded him of a case which he put on record, as remarkable and obscure as Schlesinger's. In his case there was anti-peristalsis of the stomach although no stenosis of the pylorus could be observed by the Röntgen rays. There was also phenomenal movement in the region of the vagus in the same individual.

Beer said he had seen a patient who could cause the same sound at will, in another the tick of a clock could be heard by the movement of the uvula and velum. The latter was the result of a psychical injury where the patient had been saved from drowning. CORRESPONDENCE.

ISOLATED MULTIPLE ARTERIAL DISEASE.

Herman Schlesinger exhibited a male patient, æt. 38, with arterial, probably syphilitic, disease of the carotid, subclavian, and femoral arteries of the left side. All of the tests had Wasserman's positive reaction in an accentuated form.

Wiessel said he understood this to be a central form of stenosis caused by calcification of the medial covering of the artery promoted by the syphilitic

virus.

POLYCYTHÆMIA RUBRA.

This is a disease attributed by many authors to tubercle of the spleen which is probably the true attology of the disease as was shown to be the case in a preparation he exhibited to the members where the spleen was highly tubercular.

The primary virus seems to have been conveyed from a centre in the lungs or genitals where it was originally located. For a year before death the polycythæmia existed in an aggravated form.

Scleroderma.

Stoerk showed a few cases of this disease whose

fundamental change was in the fibrous tissue of the skin, having been induced by sub-acute cellulitis or other inflammatory conditions of the muscles and bones. Having once localised itself the disease assumes many phenomenal forms. It is universally admitted that the fibrous tissue is the local lesion, but the proximate changes are assumed to be of a neuro-

genic character; by others an angio-tropho-neurosis; the latter being the most probable.

Noorden recorded a case of scleroderma where thyreoidin and glycosuria appeared; the former disappearing after medical treatment, but the latter

Stoerk remarked that his case had also glycosuria, which shows a close relationship between this disease and scleroderma. He could not discover any history in his case of thyreoidin, although it may have existed in a minor form.

SERUM AND HÆMORBHAGE.

Wirth gave the members an exhaustive exposition of the serum treatment in eight cases where he was unable to control persistent hæmorrhage by ordinary means, but succeeded with injections of serum obtained from the horse. The respective cases were tonsillotomy effects, nasal hæmorrhage in a case of arterio-sclerosis, hæmoptysis in phthisis, and hæmor-rhage from the bowel. One injection of the serum was usually sufficient to check the hæmorrhage. Where practicable serum was applied locally, such as the nose where a mop of wadding could be inserted after drenching it well with the serum diluted in water. For bleeding from the bowel a clyster of the dilute serum was effectual. In hæmoptysis the best form of administering the serum was by injection, in which it was prompt in four cases, as on the third day no blood could be observed in the sputum. The injections were given subcutaneously in doses of 20 cubic centimetres of the serum taken from the horse. He observed that the serum was much more reliable in this form than the oft used gelatine.

ACROMEGALIA, OSTEOMALACIA, AND STRUMA.

Müller presented a young woman who had all the
symptoms of deep-seated disturbance of the glandular system with internal suppression of the secretions. The prominent external evidence were acromegalia, osteomalacia, and struma. The patient complained of headache, vertigo, angio-neurotic phenomena in the legs, and great reduction in visual acuity. Both kneejoints were so greatly thickened and altered that the patient could only move with difficulty. Both adductors suffered from cramp while the symphysis pubis had the characteristic bill, or pigeon-breast

appearance.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

EDINBURGH UNIVERSITY.—Among the list of names of prospective recipients of the degree of LL.D. at the forthcoming Spring Graduation Ceremonial are those

of Emeritus Professor Alexander Crum Brown, M.A., of Emeritus Professor Alexander Crum Blown, M.A., M.D., D.Sc., LL.D., F.R.S., and Sir Alfred Keogh, K.C.B., LL.D., Director-General of the Army Medical Service. Professor Kronecker, University of Berne, the Hon. Lord Dundas, and Mr. J. M. Barrie will also receive the same honorary degree at the ceremonial.

GLASGOW UNIVERSITY.—At the last meeting of the University Court the results of the September preliminary examination came under discussion. It seems that of 227 candidates only 28 satisfied the examinersthe percentage of failures was 87 per cent., whereas in Edinburgh, Aberdeen ,and St. Andrew's, on the same papers, the average "plough" was only 59 per cent. The Court appointed a committee to inquire into the matter, and the committee naturally applied to the convener of the Joint Examination Board for permission to scrutinise the rejected papers. The Board, however, declined to allow this, and while admitting the extremely low pass, stated that they saw no reason to question the competency of the Examiner in English, nor to hold a second examination. In the face of this non possumus attitude the Court appear to have been in some difficulty. Probably most impartial persons will agree with Dr. McVail in thinking that many perfectly competent candidates have been rejected, and that the examination was a pedantic redtape examination. It is on the face of it ridiculous that on the same papers 48 per cent, of Edinburgh candidates pass, and in Glasgow only a quarter of the number. Uniformity of examination cannot be attained by uniformity of papers alone; there must be some common ground among the examiners as to the standard of answers desired.

REGISTRATION OF NURSES.—It has for some time been felt that the provisions of the Bill for the Registration of Nurses are unsuitable for the conditions existing in Scotland, and the subject has been under the consideration of an influential committee appointed some time ago by a meeting of physicians, matrons, and hospital superintendents and others directly interested in, or affected by, the proposed system of registration. This committee has just issued a report, in which they suggest a Registration Bill exclusively applicable to Scotland. The present Bill is, they believe, ill-adapted to local needs, but a separate Registration Council in Scotland would stimulate and promote the training of Scottish nurses in a way that a Registration Council sitting in London would not do. It also seems to the committee that all the advantages of a scheme of registration embracing the whole kingdom would be obtained by insisting in any Bill a clause providing that nurses registered in England or in Ireland should also be registered in Scotland. The registration fee of five guineas is regarded as excessive; in the draft

Bill it would not exceed two guineas.

ROYAL MEDICAL SOCIETY'S BANQUET.—The annual dinner of the Society was held in the Society's rooms on February 9th. The Senior President, Dr. Kelman on February 9th. The Senior President, Dr. Reiman McDonald, presided over a gathering of nearly one hundred. The guest of the evening was Principal Sir Donald MacAlister, who proposed the toast of the Royal Medical Society. He spoke of its long existence, extending into three centuries, and of the great names on its roll—Oliver Goldsmith, Darwin, Lister. Going on to speak of medical education, Sir Donald MacAlister said that the Medical Acts had a strictly practical end in view. They bid the General Council see to it that a doctor had the requisite skill and efficiency. A University might impart to, or ask from its graduates more than the minimum; it might insist more "knowledge," but it might not be satisfied with less "skill." Greater proficiency on the one side must not be purchased at the cost of less efficiency on the other. Modern advances in medicine had put new powers into the doctor's hands. But to learn to use them skilfully needed more study in the wards and more practice at the bedside than before. For that more than the second half of the curriculum was required. When the two half sections were more than the whole could contain, something must give. Should it be the first, or the second, half? He commended that as a practical problem worthy of its statesmanship. The solution which was barred was that which would

crush out, or crush up, the second half. The reputation which Edinburgh had won could be kept only by bettering the methods which had in the past enabled them to win their position. The best of teaching would fail if the student had not time to profit by it. Clinical skill could not be crammed. Time and a certain detachment of mind were factors in the product. If these were stinted practical efficiency suffered, and it was by their practical efficiency that doctors must, on the end of the day, stand or fall. It would not become him to forecast, even if he could, the changes that might be needed to secure them against the curtailment or overcrowding of the clinical part of the curriculum. When the need arose, if it had not already arisen, he hoped they would be granted power to institute and to modify the necessary changes. The Medical Council would look after the minimum curriculum; on the super-minimal, after the bare essentials were provided, on the higher instruction and the stricter standard, does the special reputation of a school or university chiefly depend.

#### BELFAST

Queen's University Medical Students' Association.—A meeting of this Association was held on Thursday, February 11th, in the Students' Union, Queen's College, when a paper was read by Dr. H. L. McKisack on "The Medical Student." There was naturally a large attendance of students to hear what one of their most popular clinical teachers had to say upon them. Dr. McKisack's paper was a happy mixture of wit and wisdom. From his position as secretary of the Medical Staff at the Royal Victoria Hospital he was able to point out some of the failings of the student of to-day, but his he did in such a friendly way that none could take offence. The recollections of his own students days in which he indulged also served to show that when he gave good advice as to work, athletics, and so on, he was in the position of the commercial man who said, "Honesty is the best policy; I have tried both." Referring to the frequent complaints of various grievances made by the Association, he came to the conclusion that these grievances, all things considered, were not very serious. He advised every man to have at least one hobby, and commended the latest College movement, the foundation of the Officers' Training Corps. Professor Lindsay congratulated the students on their society, and referred to recent improvements in the College. Professor Symmers, in an amusing speech, referred to Dr. McKisack's advice on various points, and said his would be that they should make bacterioand state the students also spoke, and criticised their teachers. Their principal complaint was that they did not want to be made into anatomists or physiologists—they wanted to be doctors!

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

"THE OPERATION CRAZE."

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—The aseptic and antiseptic ritual having contributed so much towards the safety of patients obliged to submit to operation (some, unfortunately, under the delusion that medical aid or common sense advice can do nothing for them), has now led to the extreme of endeavouring to cure all by a "short cut" and without daring to imply that operation pays the surgeon best, the physician is now almost altogether ignored; and when death occurs soon after any operation the usual convenient diagnosis is made of "heart failure," so commonly noticed in the daily papers! (40 last year at least). Had a physician been consulted in cases where fatal operation was not immediately imperative, and where fatal results accrued, he might have been able to assist the heart and prepare the patient for operation—almost as important, if time permits, as the operation itself!

Every conscientious surgeon must sometimes be reminded of cases in which he was tempted to operate, and which he now regrets, as having, perhaps, unwittingly hastened the patient's demise. How many healthy ovaries have been removed? How many breasts sacrificed from mistaken diagnosis, or, worse again, from mistaken zeal? organs, the loss of which can never be replaced, and by reaction alone on the patients' nerves contribute to the increase of lunacy (at least in neurotic subjects).

Easier to cut a string than unpick a knot, and while admitting the undoubted value of operation in cases where time will not permit of any delay, or in cases where all other treatment has failed, I think I can get some medical men at least to agree with me, that it is time halt was called and operations only undertaken in cases to which the lines in italics applied.

THE NEWSPAPER PRESS AND QUACKERY.

I am, Sir, yours truly,
ALEXANDER DUKE.

London, W.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—In leading articles, and in the correspondence
pages of your paper, the remarkable and deplorable
change of conduct of the Times with regard to quack advertisements has recently been fully exposed and commented upon. The *Times* until lately stood alone among its contemporaries. In its business, no less than in its editorial department, it was in truth the "leading" journal. It sacrificed an income of thousands a year by refusing advertisements of questionable character, readily accepted by every other paper. Now, as you have shown, the *Times* constantly publishes advertisements the character of which is denounced in its editorial columns, and these advertisements may even appear in juxtaposition with the article condemning them. The editorials referred to must really serve as puffs for the quackery; the simple reader naturally believing that no deceptive advertisement can possibly appear in so high-toned a paper. The Daily Telegraph of to-day, Feb. 3rd, follows the example of the Times. It publishes an article headed, "The Drug Habit: An Increasing Evil." The article very ably exposes the evils of the traffic in quack medicines of all kinds. "The prevalence of self-drugging threatens to undermine the moral and physical wellbeing of the community. The habit has been steadily growing for years, and has now assumed such growing for years, and has now assumed such alarming proportions as to have become a matter of grave national importance." In almost the same words that I employed some weeks ago in the MEDICAL PRESS, it first exemplifies these evils by reference to "indigestion" cures, and illustrates them by reference—as I did—to cases of gastric ulcer in which patients often dose themselves until their malady has assumed a mortal phase before seeking medical advice. The article then goes before seeking medical advice. The article then goes on to show the pernicious character of sham tonics containing alcohol, cocaine, etc., employing language practically identical with that which you quoted last week from a similar editorial in the *Times*. For one advertisement of these pernicious compounds that appears in the *Times*, for every one advertisement of a quack medicine which ought not to be accepted by any paper standing in the first rank of journalism, which appears in the Times, a score appear in the Telegraph. The Telegraph, unlike poor provincial papers which plainly state that they "cannot exist" without the income derived from quack advertisements, is making more money than any other newspaper of the day. It has ten or twenty times more advertisements of every class than the *Times*; its editorial expenses of every class than the *limes*; its editorial expenses are perhaps a quarter as great. It is incredible that its noble owner, who has gained his title, his position, from his paper, can be cognisant of the injury that is being inflicted upon the simple, suffering public by all the forms of medical quackery; he cannot be in the least aware of the facts which the article in his own power today demonstrates. Surely the

article in his own paper to-day demonstrates. Surely the motto, noblesse oblige, should apply here. Surely this distinguished nobleman would revolt with disgust from receipt of any income derived from any source

much less tainted than that indicated by his able contributor. It is impossible to believe he is aware of these facts. Is it not possible for you, Sir, to make a personal appeal to him, and to the proprietors of all the leading papers in this matter? Can you not make plain to them, by reference to their own editorial utterances, the extent of the evil they are quite unconsciously abetting? Can you not by some means contrive to reach directly the eyes or ears of the proprietors of our great papers? The movement for a Royal Commission on Quackery now taken in hand by the British Medical Association and the General Medical Council would be brought to a speedy successful issue if supported by papers like the *Telegraph* and *Times*. The case for legislation against quackery is overwhelming; it only needs stating with authority to compel the immediate attention of Parliament. If the great papers would help in this movement they might confer upon the people a benefit as great as any of those which, largely through their efforts, have been those which, largely through the state of th

February 3rd, 1909.

#### THE CENTRAL MIDWIVES BOARD AND

SEPSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-In any investigation of the ætiology of puerperal sepsis undertaken in the future, the regulations of the Central Midwives Board must not be over-looked. It is presumably the function of this body to exert itself for the protection of the public against the ministrations of ignorant or careless midwives. It has hitherto performed its duties in such an erratic and irresponsible manner that one hardly feels sur-prised at any of its actions. Nevertheless, all who are interested in obstetric education will be startled at the latest folly of the Board. In a resolution interpretive of one of its regulations, and having the force of a regulation, it is laid down that a midwife during her training must have made "repeated vaginal examinations" of her patients. For the past ten years at least it has been the teaching of all reputable obstetric authorities that in the interests of asepsis, vaginal examinations should, if possible, be avoided altogether. This is the maxim of such writers as Dr. Whitridge Williams, of Johns Hopkins, Dr. Jellett, and Dr. Tweedy, of the Rotunda Hospital, and its justification is found in experience. Yet the Central Midwives Board direct that candidates for registration shall have made "repeated vaginal examinations." vaginal examinations.
I am, Sir, yours truly,
PATHOLOGIST.

#### AUSTRALIA FOR THE SONS OF PROFESSIONAL

#### To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Since my letters dealing with the opportunities offered by Australia to the sons of professional men have appeared in your columns, I have received a large number of communications from doctors, lawyers, chemists, etc., who are anxious to send their sons to Australia and enter them at one of the Agricultural Colleges here or get them straight on to a farm. great has this response been that I have decided to attend the next Annual Meeting of the British Medical Association at Belfast, and seek there an opportunity of bringing the advantages of land settlement in Australia before the members of the Association who may be interested in the subject. I hope to be in London by May, and letters addressed to me at the Royal Colonial Institute, Northumberland Avenue, W.C., will be promptly attended to.

In the meantime, illustrated prospectuses of the various Agricultural Colleges can be obtained by application to Captain Collins, Commonwealth Offices, Victoria Street, S.W., and if any gentlemen decide to send their sons out at once, so as to arrive here in April or May, which is a favourable time of the year for doing so, I should be much obliged if they would notify this to the Secretary of the Immigration League of Australasia, 14, Moore Street, Sydney.

At several of the Colleges in New South Wales, the fees for board and tuition are to be reduced to £10 or £12 per annum, which should bring this invaluable course of agricultural training within the reach of everyone.

I am, Sir, yours truly,
RICHARD ARTHUR, M.D.,
President, Immigration League of Australasia Sydney, December 28th, 1908.

#### THE DUTY ON COCOA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-Judging by speeches delivered in various parts SIR,—Judging by speecnes delivered in the duty of the kingdom, our attitude with regard to the duty misunderstood. We have upon cocoa is apparently misunderstood. We have never asked for Protection on cocoa, and for many years no change has taken place in the duty.

The duty on cocoa is raised for revenue and not for Protective purposes. It is in the same category as the duty on tobacco, coffee, wines, etc. The duty differentiates between raw cocoa and manufactured cocoa, that upon raw cocoa being rd. per lb., and that upon manufactured cocoa 2d. per lb. This differthat upon manufactured cocoa ad. per lb. This difference is not primarily designed to give the home manufacturer an advantage, but to place him on an equality with the foreign competitor in the home market. In converting the raw material into manufactured goods there is a large loss resulting from the removal of imperfect beans, dust, outer husks, etc., and loss of weight in roasting. It is to allow for this wastage that the differential duty, as between the raw material and the manufactured product, is imposed. A similar differentiation exists in regard to tobacco, coffee, etc. On cigars double the duty is paid that is paid on unmanufactured tobacco, whilst on raw coffee the duty is 14s. per cwt. against 18s. 8d. per cwt. on roasted coffee. In each case there is a slight advantage to the British manufacturer. In the case of cocoa it amounts to only 2 per cent., or something between one farthing

and one halfpenny per pound.

But even this advantage is counterbalanced by the absence of any rebate or drawback on exported cocoa. On every pound of manufactured cocoa we export we pay 11d. duty, the 1d. representing the difference between a pound of raw cocoa and a pound of manufactured cocoa. By the absence of drawback the home manufacturer is handicapped to the extent of nearly 6 per cent. in comparison with his foreign competitor in neutral markets. In Holland, for example, there is no duty on raw imported cocoa; in France and Germany drawback is allowed on exported cocoa.

The existing duty upon cocoa only illustrates the

difficulty of applying tariffs with absolute justice as between all the interests involved, and we are convinced that the removal of the present duty upon one of the important foods of the people would be a gain to the consumer, and would involve no loss to the manufacturer.

We may add that we have consistently advocated for many years the abolition of the duty on cocoa as on other articles of food.

Yours truly,

CADBURY BROS., LTD.

Birmingham, February 11th, 1909.

[Our readers will understand that we publish the above communication without in any way committing ourselves to any economic point of Tariff Reform, one way or the other. The food question is clearly one of interest to medical men.—ED. M. P. AND C.]

#### **OBITUARY.**

WILLIAM PARSON, M.R.C.S.

WE regret to announce the death, at Godalming, of Dr. William Parson, an ex-mayor of the borough, at the age of 74.

Dr. Parson was medical officer of health at Godalming for 27 years, and was an ex-master of the Apothecaries Company. He was made a magistrate soon after the commission was granted to the borough of Godalming in 1870. He became a member of the

Royal College of Surgeons in 1855, and a licentiate of the Society of Apothecaries in 1856. He was at one time house surgeon to the Hospital for Sick Children, Great Ormond Street.

#### REVIEWS OF BOOKS.

#### DIPHTHERIA IN PRACTICE. (a)

This little manual gives an account of diphtheria based on the experience of the author. It does not pretend to be an exhaustive treatise on the disease, but rather to deal with those points which give rise to difficulties in practice. The author lays great stress on the importance of the clinical as opposed to the bacteriological diagnosis of the disease. In this we are in full agreement with him, but we are also convinced that the ultimate court of appeal, in every case, and not in the so-called doubtful cases only, is the finding of the bacteriologist. Before the days of bacteriology, when observers were at least as compe-tent as they are at present, it used to be taught that the only way to be sure that those patients who had sore throats and recovered from them, had diphtheria was the advent of paralysis. At present we believe that if statistics of treatment are to be of any use in this disease, only those cases in which the diagnosis is verified by bacteriological examination should be included.

Dr. Litchfield is a firm believer in the value of the anti-diphtheritic serum, and advocates doses which appear to us unnecessarily large. The immediate administration of 4,000 units to a patient with mild faucial diphtheria, does not, we believe, give better results than the administration of half that quantity, and is much more likely to be followed by symptoms, which even if they do no harm are unpleasant to the which even it they do no harm are unpleasant to the patient. We confess we do not quite follow our author's meaning when he says "that post-diphtheritic paralysis is not due to a peripheral neuritis. The lesion is a parenchymatous degeneration of the nerves, which is most marked in the peripheral branches." Further, we do not know if he has any histological confermed to support his contention "that the diphtheric evidence to support his contention "that the diphtheria toxin injures the nerves, and that they subsequently degenerate under the stress of function." From a clinical point of view the hypothesis has much to recommend it, but we should have wished also for some histological proof of it. The book is interesting and will repay perusal.

#### A MANUAL OF MIDWIFERY. (b)

THE second edition of this excellent, if somewhat theoretical, work, seems to us to be an advance upon the first, because somewhat more attention has been paid to the practical aspect of obstetrics. Fifty additional pages of reading matter have been added, and they have been exclusively devoted to practical matters, which we are glad to see the author admits were unduly compressed in the first edition. "Thus a good duly compressed in the first edition. "Ihus a good deal of additional space has been devoted to the subjects of Abdominal Palpation, the Puerperium, and Infant Feeding." This is quite right, but there are many other practical subjects which also urgently demand additional space, and we think Dr. Eden would have been well advised if he abandoned part would have been well advised if he abandoned part of the anatomical descriptions with which the book abounds in order to make the necessary space.

Perhaps, however, in a way, Dr. Eden is wise in devoting more space to the subject in which he is an criginal expert, and less to the subject in which he is apparently so hampered by what one must call case-

hardened London teaching; and case-hardened London teaching, though a knowledge of it may be good for the student "who has the fear of the examiner before his eyes," is not good for the advancement of modern obstetrical practice. At the same time we recognise that Dr. Eden has made a distinct effort to break away from the influences of hereditary teaching, and that in many instances he has been signally successful.

The treatment of face and brow presentation, as described by Dr. Eden, is very sketchy. In the case of the former presentation we are told that Herman's method of flexing the head is best. If so, it must be erroneously described, for how pressure on the forehead of an extended head "first raises the presenting part above the brim, and then commences to flex the head" is unintelligible. We are told that morphia should not be given to an eclamptic patient if she is comatose or when chronic nephritis is suspected. Without entering into the merits of the morphia treatment of these cases, we may say that if these limita-tions were universally accepted there would only be a limited scope for the treatment, whereas those who

adopt it do so in practically all cases.

There is no description or apparent mention of publiotomy, although there is a description of vaginal Cæsarean section. We thought it had been settled for quite a long time that the head entered the pelvic brim in a synclitic and not in an asynclitic position, and yet Dr. Eden brings out the old heresy. Fig. 95, which he gives as a reason for thinking there is asynclitism, to our mind shows the head in a synclitic position, are rether would do so if the asynclitic position. position, or, rather, would do so if the pelvis had been shown too. It must be remembered that in a synclitic position of the head the anterior parietal bone lies lowest because the plane of the brim is oblique, but still this is an extended in a synclitic position. oblique, but still this is an anterior parietal presentation.

There are quite a number of plates, and they are good and well reproduced. There is an especially good set of drawings showing the application of forceps, but Dr. Eden as a bacteriologist, as a pathologist, and even as a practical obstetrician, no matter of what school should really recognise that rubber gloves are essentials whose use should be taught by precept and by example. Dr. Eden details on page 219 the conditions under which rubber gloves should be worn, and they are not convincing. We have not come across a drawing in the book in which the operator wears them. The illustrations in the text are numerous; some are original, and many have been borrowed from other sources. As a whole they would be good if either the author or his publishers had not thought it necessary to convert the half-tones of others into ugly line drawings.

In conclusion, we have only to say that, though personally we do not care for Dr. Eden's work, we recognise that it is an excellent exposition of London teaching, and that in its more theoretical portions it is one of great originality and merit.

#### THE SEXUAL QUESTION. (a)

THE author postulates a sexual question pregnant with untold consequences to the happiness and physical well-being of countless millions of as yet un-born, nay, unconceived, human beings. What that question is we are at a loss to discover, although the author defines his object "to harmonise the aspirations of human nature and the data of sociology of the different human races, with the results of natural science and the laws of mental and sexual evolution which these have revealed to us."

Writers on this subject invariably commence by deploring the quasi-ignorance of the young in relation to sexual matters, although, if we look into the matter, we shall find that it is not so much ignorance as lack of instruction. That, at any rate, is a matter that admits of discussion, nay, calls for it though, when it comes to the actual initiation of the young, very

<sup>(</sup>a) "Diphtheria in Practice." By W. F. Litchfield, M.B.Syd, Hon. Assistant Physician, Royal Alexandra Hospital for Children, Sydney. Octavo, pp. 96, with 14 illustrations. London: Bailliere, Tindall and Cox. 1908, Price 3s. 6d. net.
(b) "A Manual of Midwifery." By Thoma Watts Eden, M.D., F.R.C.P., F.R.C.S.E.d., Obstetrical Physician with charge of Outpatients, and Lecturer on Practical Midwifery and Gynecology, Charing Cross Hospital; Physician to Out-patients, queen Charlotte's Lying-in Hospital, &c., &c. Pp. xii, and 555, with 42 plates and 236 illustrations in the text. Second Edition. London: J. and A, Churchill. 1908.

<sup>(</sup>a) "The Sexual Question." By August Forel, M.D., Ph.D., LL.D., formerly Professor of Psychiatry and Director of the Iusane Asylum in Zurich. English adaptation by C. F. Marshall, M.D., F.R.C.S., late Assistant Surgeon to the Hospital for Diseases of the Skin, London. London: Rebman Ltd.

few parents will have the necessary courage, possibly because they themselves require to be first trained.

But supposing we grant the premises and concede that such instruction should be given, does the author suggest that it should take the form of such a work as he has placed in our hands? Are the young, in addition to the practical, working details of sexual intercourse, as given here, to be placed au courant of every individual aberration of the genital instinct, every irregular sexual instinct, from sodomy to sadism, every erotic elucubration of the genitally insane?

It is difficult to resist the conclusion that the education of the young was about the last thing in the writer's mind when he penned this work, which is an enlarged, but not a revised, edition of Acton on the Reproductive Organs. We can quite understand the author's introductory reproach addressed to the French public (of all publics!) they they "are too much afraid of crudities and of calling things by their proper names." It must be conceded that the author does not shrink from the plainest of speaking, and when he has done with a subject there is assuredly very littleft to know. All the same, the mind of the "intelligent, virtuous, educated, and well-brought-up young girl, 21 years of age," whose letter of "grateful thanks" the author embodies in his preface, would be an interesting study, and her conversation would not lack piquancy.

If we could imagine any possible useful purpose to be served by works of this kind we should not shrink from plain-speaking; but, honestly, it appears to us merely to pander to the morbid taste of prurient people. The greater part of it is concerned with practices, a knowledge of which could not be turned to useful account even by a medical man, and to place such information in the hands of the general public is absolutely inexcusable. It is not even nominally addressed to the medical profession, specious though the pretext would have been, and if its publication be allowed to pass unchallenged the law forbidding indecent literature must henceforth rank as a dead letter.

The translator's part is of indifferent quality, abounding in split infinitives and embarrassed phraseology. We are unable to congratulate him either on his choice of a subject or his manner of dealing with it

#### MEDICAL NEWS IN BRIEF.

#### London Fever Hospital.

THE annual general meeting of the Governors of the London Fever Hospital was held on February 12th. Lord Balfour presided. Mr. Norman presented the that only £665 was received in legacies, being £5,000 less than in 1907. Dr. Sidney Phillips, the Senior Physician, read the report, which showed that the total number of patients under treatment during the year was 762, or 90 less than in the previous year, the decrease being due entirely to the lessened number of cases of German measles admitted. Sir Thomas Barlow, in moving the adoption of the report, urged the establishment of voluntary pay hospitals, throughout the country. He would regard it as the greatest possible calamity if the hospitals of the country were all placed under State or municipal administration. The hospital needed help, and he appealed to all who believed in the voluntary system to help it in the good work it was doing. The report was adopted. Lord Balfour said that the institution was doing a great work among that portion of the community which ought not to be allowed to go to public institutions because its members could do something for them. But they could not do everything, and if nothing were done for them in the way in which the institution was doing it they were forced to sponge on the public funds. There were three classes in the

community—those who could not pay anything at all, for whom the community ought to do the best it could, those who could afford to pay for everything necessary for the cure of those dear to them struck down by disease, and a class who could not pay the whole, but could pay part. The London Fever Hospital catered for the last two classes.

#### Needs of Cardiff Infirmary.

At a meeting at the Cardiff Infirmary on February 9th, General Lee presiding, it was said that the treasurer's bank pass-book showed a balance of £16,231 due to the bankers. Payments were authorised for £1,560, thus increasing the overdraft to £17,791, being £6,369 on capital expenditure and £14,422 on working account.

Dr. Tatham Thompson, Chairman of the Medical Board, reported that three applications were received for the post of House-Surgeon, and that Mr. R. V. V. Vaughan had been unanimously appointed and had taken up his duties.

Draft copies of the annual report were presented, and showed that during the year 2,245 in-patients were treated and 16,323 out-patients. The board regretted that a considerable increase in the cost per bed was revealed, but assured the governors that this increase had not resulted from any want of economy in the management of the affairs of the institution. There were various special reasons for the enhanced cost. The income for the year amounted to £12,102, and the expenditure to £15,849. The income had usually fallen short of the expenditure by nearly £3,000. The maintenance of the new wing would involve an additional annual expenditure of £4,000, and it was, therefore, necessary that £7,000 additional income should be assured before the expenditure was balanced by the income, and the board was determined that the new wing should not be opened until this satisfactory result was attained.

#### Notification of Births.

ABOUT a year ago the question of adopting the Notification of Births Act in the city of Aberdeen was before the Public Health Committee of the Town Council, and then, after consideration, it was agreed to receive a deputation from the Aberdeen Medico-Chirurgical Society. The members of the deputation urged certain reasons for delay, and the request for six months' delay was agreed to. More than 12 months have now elapsed, and the matter was brought before a meeting of the Public Health Committee on February 10th, Councillor Kendall Burnett, the convener, presiding. The committee unanimously resolved to recommend the Council to adopt the Act after the lapse of a month, during which any objections to that course of procedure may be considered.

#### The Prince on Tour-

The Prince of Wales paid a private visit on February 12th to the Great Northern Hospital, Holloway, and made a tour of the wards. His Royal Highness also visited the new ward for children, which is to be declared open by the Princes of Wales on the 22nd inst. The Prince inspected the whole of the premises, and expressed himself as being much pleased with everything he saw. He was accompanied by Sir Francis Laking, and was shown round by the assistant matron and the resident medical officer, Dr. Wade.

#### Death During Operation.

AT Westminster, on February 10th, Mr. Troutbeck held an inquest on the body of George Alfred Wisking, aged 29, valet to Lord Claud Hamilton, who died whilst undergoing an operation.

The deceased was suffering from a throat affection, and was ordered an immediate operation. Examination at St. George's Hospital showed that the deceased had a swelling of the face and neck, which prevented him opening his mouth more than half an inch. An abscess under the tongue, apparently caused by some stumps of teeth, had pushed the tongue against the roof of the deceased's mouth. An operation was immediately performed to reduce the swelling, and just as it concluded the deceased stopped breathing.

In the opinion of the surgeon and the anæsthetist, death was due to the swelling of the glottis causing suffocation. This would have occurred if the operation had not been undertaken, but the operation, which was the only chance of saving the man's life, accelerated his death.

The jury returned a verdict in accordance with the medical evidence.

#### Health of London School Children.

INTERESTING facts about the health of London school children are contained in the report on the medical examination of candidates for scholarships made to the County Council Education Committee. Out of a total of 2,848 boys and girls examined last year, no fewer than 1,227 were found to be physically unfit. Very few were absolutely rejected, the great majority being passed, after receiving medical treatment. It is, however, stated that a considerable number of these

were of very poor physique.

Defects of teeth, vision and throat were most common, but several candidates ultimately accepted were found to be suffering from such complaints as heart disease, middle ear disease, high myopia, lateral curvature, and severe anæmia. In the case of junior county scholars, aged from 10 to 12, 1,015 were declared fit, and 790 unfit, and 171 of the latter were referred back for two, and twenty for three defects. Of the 549 candidates for probationer scholarships, awarded to enable pupils to become elementary school teachers, more than half were below the standard, and 74 were suffering from more than one defect. As many as 297 candidates had not been vaccinated.

#### irish Medical Association—Fermanagh Branch.

AT a meeting of the above Association the following resolutions were passed:—Resolved: Though large sums of public money are paid to those who instruct the public in agriculture, dairying, fruit culture, the technicalities of various trades, the care of cattle, fowls, bees, etc., etc., and notwithstanding that the community is taxed for the maintenance of hospitals and sanatoria for the treatment and cure of disease much of which is preventable—no public money has hitherto been available for the remuneration of those properly qualified to instruct the people in matters of hygiene and the preservation of their health. that the Legislature has at length recognised public health lectures as a subject of technical education, and as one entitled to share in the local grants, it is no longer necessary to regard the services of the profession in lecturing and instructing the people as a matter of philanthropy. And while we consider that such philanthropic societies as the Women's National Health Association are deserving of every sympathy and encouragement, we are of opinion that their existence is the strongest possible proof and condemnation of the neglect and incapacity of the Government, central and local, in matters of sanitation and public health. We are further of opinion that medical men should not lecture under the auspices of such philanthropic societies, or at all, unless adequate remunera-tion be provided, and we suggest that these societies should co-operate with the County Councils for the selection and remuneration of suitable lecturers. We desire to point out that if medical men continue to give public health lectures gratuitously philanthropy will be usurping the functions of the Government, and local authorities will never be given the opportunity of exercising their newly-acquired powers of paying for lectures and instruction in hygiene and public health.

#### Compulsory Irish in the New National University.

A MEETING of Dublin students was held last Monday night in order to demonstrate to the public their devotion to the cause of compulsory Irish. The meeting was held in the Round-room of the Mansion House. A resolution was adopted expressing the opinion that no one could be considered educated unless he has received instruction in the language and history of his country, and calling on the Senate of the National University of Ireland to make a knowledge of the Irish language and of Irish history and service of the Irish language and of Irish history and the Irish language and of Iri ledge of the Irish language and of Irish history an essential part of the education of every student at entrance and up to the point at which specialisation begins. Subsequently a torch-light procession was

On the other hand the following petition to the Senate of the National University has been signed by seventy students of the Catholic University School of Medicine:—Gentlemen,—Seeing that a meeting, purporting to represent the opinion of the whole student body of Dublin, has been convened to support the demand for compulsory Irish in the National University, we, the undersigned, representing a considerable number of the students of the Catholic University School of Medicine, Dublin, do hereby wish to dissociate ourselves from that demand, while at the same time we believe that every facility should be afforded for the voluntary study of Irish.

The arguments in favour of our position against coercion have been too fully stated to require reiteration here.

#### The Prince and the College of Surgeons of England.

At the ordinary meeting of the Council, held on February 11th, the President (Mr. Henry Morris) announced that the Prince of Wales had consented to become an Honorary Fellow of the Royal College of Surgeons of England. The votes of the Council were thereupon taken in accordance with the requirements of the charter of the 63rd Vict., and the President declared his Royal Highness to be duly and unani-mously elected an Honorary Fellow of the College. The diploma was presented to his Royal Highness, in the presence of the Council, on Monday, February 15th, when, as has been already announced, the Prince and Princess honoured the College with their presence at the delivery of the Hunterian oration by the President.

#### The Will of Sir Arthur Macan.

SIR ARTHUR VERNON MACAN, M.B., B.A., F.R.C.P.I., of 53 Merrion Square, Dublin, President in 1903 of the Royal College of Physicians in Ireland, and for many years King's Professor in Midwifery in Trinity College, Dublin; an authority on Obstetric Surgery, and President of the Obstetrical Section of the Interand President of the Obstetrical Section of the International Medical Congress, and of the Obstetrical Section of the Royal Academy of Medicine, and of the British Gynæcological Society, who died September 26th last, aged 65 years, eldest son of the Hon. John Macan, Q.C., a former Judge of Bankruptcy in Ireland, left personal estate in the United Kingdom valued at £25,924 19s. 3d. Probate of his will, dated September 24th last, has been granted to his brother, Dr. Jamieson John Macan, M.D., of Crossgates, Cheam, Surrey, and Miss Dorothy Vernon Macan, of ca Merrion Square Dublin, and probate has been 53 Merrion Square, Dublin, and probate has been renounced by Mr. William Edward Peebles. The testator left his mifwifery instruments and objects for the teaching of midwifery to Trinity College, Dublin; his French and German medical books and his English books on midwifery to the Royal College of Physicians, Ireland; his other medical and surgical instruments to Gibbon Fitzgibbon and Arthur Holmes, and the residue of his property to his children—Arthur Vernon, Leila Vernon, Dorothy Vernon, Leslie Fitzgerald, and Eleanor Vernon Osborne.

#### Conjoint Examinations in Ireland.

THE following candidates have passed the final THE following candidates have passed the final examination of the Royal College of Physicians and the Royal College of Surgeons, February, 1909:—
J. J. Barry, C. H. Bryan, F. S. Crean, J. J. Cuskelly, C. J. B. Dunlop, J. J. Dwyer, J. Ellenbogen, D. J. Harty, P. Maguire, J. O'Brien, M. C. O'Hara, D. O'Sullivan, W. G. Ridgway, H. N. Ritchie.

The following candidates have passed the public health examination, February, 1909.—Capt. Wm. O'Sullivan Murphy, I.M.S., M.B., R.U.I., Samuel Poole, M.D., Univ. Edin.

#### The Apothecarles' Hall of Ireland.

THE following candidates having passed the necessary examinations, have been granted the Diploma:—Charles J. Neilan, Thomas Edwin Johnson, and Edmund Smith.

#### NOTICES TO CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subsoriber," "Old Subsoriber," etc. Much confusion will be spared by attention to this rule.

#### SUBSCRIPTIONS.

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insertion; 6d. per line beyond.

insertion; 6d. per line beyond.

COTTAGE HOSPITAL.—Under the above nom de plume, a correspondent writes as to the best way of drawing up an inexpensive pharmacopæia. It is difficult to answer in a few words, but, speaking generally, a good plan is to restrict the range of prescriptions as far as possible to a few stock mixtures. Tinctures are always expensive, and should be avoided where it can be managed. Liquor strychnies, for instance, is an excellent tonic, better than can in most cases be substituted for the more costly tincture of nux vomics. With a little care and special knowledge, the cost of drugs can often be greatly cut down. A familiar example is the substitution of sulphate of iron for tincture ferri perchlor. Every practical dispenser should be able to supply lots of practical information on this subject.

DR. M. F. D.—The authority is acting entirely within its

DB. M. F. D.—The authority is acting entirely within its rights, and our correspondent admits that he was aware of, and accepted, the conditions at the time of his appointment. To complain and protest, therefore, against the terms of the agreement, at the present time, is not likely to lead to any useful result.

#### THE DOCTOR-ACTOR

ITHE DOUTOR-ACTOR.

It is pleasing to realise that Sir O. Wyndham, from his early training as a doctor, was able in a measure to relieve the pain from which he found his great French confrère, M. Coquelin, suffering when he paid him a visit. Sir Charles, as is generally known, at first followed the medical profession of his father, and as a surgeon he served in the Federal Army during the American Civil War.

Civil War.

DR. E. W. S. O.—Yes, please send on the notes of the case, which appears to be interesting. (2) You had better refer to the Secretary of the local Medical Society. (3) Unless the person in question described himself as a "Surgeon," he cannot be punished. The dentists have obtained a much more pertinent definition of the trespasser—so that any pointed reference to teeth appears to be enough to bring a man within their Act.

SER JURGE (Ristol).—Undoubtedly a natient is entitled to

be enough to bring a man within their Act.

Sub Judice (Bristol).—Undoubtedly a patient is entitled to chose his own consultant, whatever a practitioner's feelings may be in regard to the choice made. But if a patient determines to exercise his own judgment in the matter, against the advice of the practitioner, the latter is naturally absolved of all responsibility of the result. It is always, however, best to acquiesce with the patient's wish, in such cases, irrespective of personal feelings.

#### Meetings of the Societies, Tectures, &c.

WEDNESDAY, FEBRUARY 17TH.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—
8 p.m.: Mr. A. A. C. E. Merlin: On a German-silver Powell
Portable Microscope made in 1850. Mr. G. S. West: The "Red
Snow" Plant Sphaerella Nivalis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenics
Street, W.C.).—4 p.m.: Mr. M. White: Clinique (Surgical).
5.15 p.m.: Lecture: Dr. G. Little: The Treatment of Syphilis.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's
General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical
Out-patient (Dr. T. R. Whipmam); Skin (Dr. G. N. Meachen);
Eye (Mr. R. P. Brooks).

THURSDAY, FEBRUARY 18TH.

Eye (Mr. R. P. Brooks).

THURSDAY, FEBRUARY 18TH.

ROYAL SOCIETY OF MEDICINE (DERMATOLOGICAL SECTION) (2C
Hanover Square, W.).—5 p.m.: Clinical Cases: Dr. MacLeod:
A Case of Lupus Erythematosus treated by Zinc Ionization. (Aud

A CARRO of LURIS ETYTHERMATORUS TREATED BY ZING IONISATION. (AMD other Carges.)

CHILD STUDY SOCIETY LONDON (Parkes Museum, Margaret Street, W.).—8 p.m.: Mr. W. H. Winch: The Age of Entry into School in its Relation to Progress.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m.: Dr. E. G. Little: The Treatment of Skin Diseases by Ionisation, Dr. F. S. Lang mead: Infant Feeding with Undituted Citrated Milk.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Cantlie: Clinique (Surgical). 5.15 p.m.: Lecture: Dr. L. Smith: The Treatment of the Failing Heart.

NORTHEAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynrecological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient

(Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture: Mr. W. Edmunds: The Diagnosis and Treatment of

FRIDAY, FEBRUARY 19TH.

ROTAL SOCIETY OF MEDICINK (ELECTRO-THERAPEUTICAL SECTION) (20 Hanover Square, W.).—8.30 p.m.: Dr. C. Thurstan Holland: The X-Ray Treatment of Exophthalmic Goitre. Dr. A. Stanley Green: The Value of Rontgen Examination in Some Conditions of Diseased Bone. Dr. A. Howard Pirie: Treatment of Tubercular Glands in Neck by means of X-Rays.

SOCIETY OF TROFICAL MEDICINE AND HYGIENE (11 Chandes Street, Cavendish Square, W.).—8.36 p.m.: Dr. H. G. Waters: A New Pathogenic Spirochesta associated with Brouchitis and Fever. Dr. T. F. Macdonald: Tropical Notes from Barbados.

MEDICAL GRADUATES COLLEGE AND POLICLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. A. Lawson: Clinique (Eye).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. R. M. Leslie).

#### Appointments.

BATTEN, RAINER WINTERBOTHAM, M.D.Lond., F.R.C.P.Lond., M.R.C.S., Honorary Consulting Physician to the Berkeley (Gloucestershire) Hospital, Clare, T. C., M.B., B.S.Lond., House Surgeon at the Chelsea Hospital for Women.

FAIRWEATHER, A. F. A., M.B., M.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Pocklington District of the county of York.

Hobbs, Edward Commer, M.R.C.S.Eng., L.R.C.P.Lond., Junior House Surgeon at the Miller General Hospital, S.E.

MUNRO, DONALD JORN, B.S., M.B.Lond., Honorary Anæsthetist to the Motroplitan Ear, Nose, and Throat Hospital, SHEARER, A., M.B., B.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Newtown District of the county of Montgomery.

THORNELY, Captain M. H., I.M.S., Clinical Assistant to the Chelsea Hospital for Women.

UBBDELL, HENRY, M.R.C.S., L.S.A., District Medical Officer by the Totnes (Devon) Board of Guardians.

#### Bacancies.

West Riding Asylum, Wakefield.—Pathologist and Assistant Medical Officer. Salary, £250 per annum, with board, furnished apartments, and attendance. Applications to the Medical Director at the Asylum.

Brixton Dispensary.—Resident Medical Officer. Salary £150 per annum, with furnished apartments, attendance, coal, and gos. Applications to the Secretary, at the Dispensary, Water Lane, Brixton, S.W.

Durham County Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, laundry, and attendance. Applications to the Medical Superintendent, Durham County Asylum, Winterton, Ferryhill.

Roxburgh District Asylum, Melrose.—Assistant Medical Officer. Salary, £150 per annum, with board, rooms, and washing. Applications to the Medical Superintendent.

Somerset and Bath Asylum, Wells.—Second Assistant Medical Officer. Salary £130 per annum, with board, lodging, washing, and attendance. Applications to the Superintendent.

Glasgow Lunacy District Board.—Mental Hospital Woodlee, Lensie.—Junior Assistant Medical Officer. Salary £125 per annum, with board, lodging, washing, etc. Applications to Dr. Marr, Medical Superintendent.

#### Births.

PANK.—On February 8th, at Hamilton Place, Market Rasen, Lincz., the wife of Harold W. Pank, M.R.C.S., L.R.C.P., of a daughter.

#### Marriages.

GALLOWAY—CABSELS.—On Feb. 15, at Christ Church, East Sheen, Surrey, Andrew Fleming Galloway, M.D., younger son of John-Galloway, of Bothwell, Lanarkshire, to Annie, elder daughter of William Cassels of Ballynella, East Sheen.

#### Beaths.

CRAIG.—On February 10th, at Ham, Surrey, William Simpson Craig, M.D., in his 80th year.

FARQUHAR.—On Feb. 14, at 40 Westbourne Gardens, Bayswater, Flora, beloved wife of Deputy-Surgeon William Farquhar, M.D., I.M.S., (retired).

MACKENZIE.—On February 13th, at 8 St. Andrew's Place, Regent's Park, London, after a few days' illness, Lady Morell Mackenzie, widow of the late Sir Morell Mackenzie, of 19 Harley Street, London.

NISBET.—On February 13th, suddenly, at Liverpool, John Tawse Nisbet, M.D., of 7 Croxteth Road, Liverpool, John Tawse Pavez.—On February 10th, at 29 Cangye Square, Clifton, George Pavey, M.R.C.S.E., L.S.A., aged 74,

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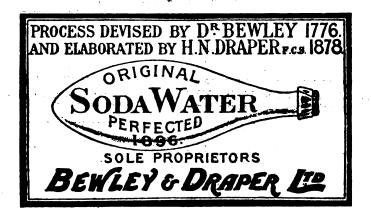
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## MEDICAL

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, FEBRUARY 24, 1909.

No. 8.

#### Notes and Comments.

Chemist and

IT may be some consolation for the qualified pharmaceutical chemist to reflect that though the Pharmacy Pharmacist. Act of last session which comes into

force next April, allows trading companies to assume the titles of chemist and druggist, it does not authorise them to call themselves "pharmacists." The bartering away of the title of "chemist" in deference to large business interests, created in a manner by no means creditable to the promoters of joint-stock retail pharmacy businesses, was the most retrograde step taken in medical matters since midwives were recognised as independent practitioners. It is, however, an accomplished fact, and the best must be made of it. The science of pharmacy may flourish in small inde-pendent businesses, but in chemical stores it will find itself ill-mated with the retailing of shoddy silver and plated wares, and such other branches of enterprise as firms of "chemists" throw out to attract customers to their shops. Obviously the business of qualified pharmacists now is to educate the public to recognise the fact that "chemist" does not necessarily mean "chemist" at all, but merely a commercial venture in drugs and anything else that people will buy. As a matter of tactics, we would suggest that duly qualified men should drop the description "chemist" altogether, and describe themselves simply as "pharmacists." In due time people would learn to distinguish between the two, and some of the harm done may be nullified.

" Dill's Diabetic

An inquest was held in Manchester last week to inquire into the death Diabetic of a man named Humby, who, Preparation." having been under medical treatment for diabetes at Nottingham,

and made great improvement, returned recently to Manchester. There he abandoned qualified advice and took to dosing himself with a mixture called "Dill's Diabetic Preparation." sold at 2s. 9d a bottle by one Mooney, a herbalist. Humby did not live long, and the medical man who was called in shortly before his death stated that with proper medical treatment life might have been prolonged for months, if not for years. Mooney declined at the inquest to say what the ingredients of his precious mixture were, but stated that he had cured hundreds of cases, and that he could cure epilepsy and locomotor ataxy as well! The Coroner instructed the jury that if they were satisfied that Humby's life had been materially shortened by the treatment, they could bring in a verdict of manslaughter. However, they merely returned the death as due to diabetes, and the Coroner told Mooney he was lucky that the jury did not connect him with the death. We are glad to

see the Coroner take so firm a stand in a matter of this kind, but cannot understand why he allowed Mooney to refuse to disclose the composition of his stuff. If it had been analysed and found to contain either noxious drugs, or even neutral drugs, it seems to us that it would have had a material bearing upon the view likely to be taken by the jury. What have the local police to say upon the point?

Mr. Bernard Shaw and the Medical

Mr. Bernard Shaw gave a lengthy, interesting, but discursive address to the Medico-Legal Society last week on the "Socialist Criticism of the

Medical Profession." He was, perhaps, hardly in his usual form as a speaker, but there were plenty of sallies and some good stories. Unfortunately, the address was mostly iconoclastic, and as far, at any rate, as the medical part of his audience was concerned, he was preaching to the converted when he detailed the woes of the practitioner and the disabilities under which he suffers. It was somewhat of a surprise to a good many of his hearers that the tone of his remarks was on the whole good-natured, and that he demonstrated more pity than contempt for the unfortunate medical men who struggle to make a decent living in poor neighbourhoods, and, in consequence, his words were well received. Of course, he could not forbear having the usual digs at vaccination, fashionable operations, and other foibles-as he regards themof the profession, but the discoverer of the "nuci-form sac" could not let pass so splendid an opportunity for bearding the lions in their den. One quite legitimate point was made by Mr. Shaw. He dwelt on the poventy of the individual practitioner, and the strain needed to keep up appearances, and from that he proceeded to show the public danger of such a state of things.

In a byegone speech, Mr. Shaw, we believe, once said that the only way to obtain honesty is to provide Prescriptions to obtain nonesty is to provide everybody with £500 a year, and paradoxical as the statement is, it contains the germ of an important truth. There are dangers from riches, but there are greater

dangers to be apprehended from poverty, and if the public wish to obtain pure, disinterested medical advice it must provide itself with a medical profession which can afford to act independently and without regard to consequences. The really extraordinary thing is that in the present welter, they seldom succeed in corrupting medical men, who as a body show an other-worldliness which is astonishing, considering the conditions under which they work. This point, too, was handsomely recognised

by Mr. Shaw. He did not, however, discover to his audience quite how present discontents were to be rectified in any practical form, and that surely is the difficulty of the position. If the profession are to rely on the State, which to the Socialist seems to be the remedy for all ills, we fear that they will only find themselves leaning on a reed which has consistently broken under them every time they put any weight on it, and is likely to break as frequently in the future. The only path of safety seems to be in self-reliance and mutual support, and when those virtues have been shown in dealing with local difficulties, the medical profession has almost always triumphed.

Pioneer Medical Science. THOSE of our readers who can find time for the foreign news—so to speak—of their profession will find much that is of interest in the recently-published report of the Well-

come Research Laboratories. There is no need in the columns of a medical journal to recall the fact that the book relates to the work carried on in connection with the Gordon College, Khartoum. It deals with an immense amount of ethnological, historical, entomological, medical and other matters of general and special scientific interest. A good instance is the observation made by Dr. Franz Werner, of Vienna, with regard to the "spitting habits of certain poisonous snakes." "For a long time," he says, "it has been a matter of discussion as to whether the often-described 'spitting' of the snakes belonging to the genus Naja is a fact or only a traveller's phantasy. Very rarely the habit seems to have been observed in the Indian Naja Tripudians, one of the best-known snakes of our globe; and I do not remember that it has been recorded in connection with other Asiatic species. Such reports as regards African najas are, how-ever, rather frequent, especially from West and South Africa, concerning in Western Africa probably Naja nigricollis, in South Africa the indi-genous Naja flava, or the same species. Had I ever doubted this fact I would have changed my opinion after seeing a full-grown speci-men of Naja nigricollis, the black-necked naja, that had just been brought to me in Gondokoro, spitting directly at my friend and companion, Dr. Sassi, after some chewing movements of the jaws. Fortunately the saliva thus ejected causes no fatal effect when impinging on the unwounded skin; and even the mucous membrane and more delicate parts, such as, more especially, the cornea and conjunctiva of the eye, often reached by the saliva, are, though liable to severe inflammation, in no real danger if the saliva is washed away at once."

The Soudanese the Soudanese medicine-man. The BarberSurgeon. Surgeon to be marked off sharply enough in the persons of the "wise physician,"

the barber-surgeon and the midwife. Some of the traits of these native practitioners, as shown in the following extract, are not altogether unfamiliar in our own experience, albeit there is an immeasurably great gulf fixed between the barber-surgeon and the British general practitioner of the twentieth century. In describing the Dervish medical man, Dr. Zeki says:—"In addition to the 'bassir,' or medicine-man of the Dervishes, there existed the 'hallag,' or barber-surgeon, and the 'daia,' or midwife, a more or less trained woman who attended to obstetric and gynæcological cases. The 'bassir' was considered the wise physician, and was entrusted with the compounding of medicines. Very

often he possessed considerable knowledge, but he took care to secure his fee before prescribing, and too often his cures were a mixture of savage quackery and charlatan tricks. The 'hallag,' who did not possess any special technical knowledge, was nevertheless regarded as a practical workman, and was a familiar figure with his razor, bleeding-horn, and circumcision clamp. It was the fashion to be bled once every six weeks, so that the barbersurgeon was kept busily employed. . . . During convalescence, especially in the case of fractures, the 'bassir' advised the patients to eat dates, said to be the most useful diet for promoting union of bone. In case of delayed union they were wont to assert that failure was due to an insufficient quantity of dates having been eaten."

#### LEADING ARTICLES.

THE MEDICAL ASPECT OF THE REPORT OF THE POOR-LAW COMMISSION.

THE Report of the Poor-law Commission issued last Thursday is, perhaps, the most momentous and important social document issued during the last hundred years, and adequately to consider and to criticise its conclusions would require almost as much space as is occupied by the Majority and Minority Reports, which together cover 500 pages. To do more than summarise in the briefest way its conclusions is all that is possible in the space of an article such as the present, and from our own point of view the medical aspect of the recommendations are the most important. As everybody knows by this time, the guardians are, in the view of the Commission, bodies to be relegated to the limbo of obscurity, and it is no disparagement to many devoted men and women who have worked on such authorities to say that the Commission has come to a conclusion which every social reformer had reached many years ago. Since the days of Oliver Twist the guardians have been synonymous for all that is bête in administration and in civilised life, and they will pass from the stage unmourned, unwept, unhonoured, but not unsung. The spirit which has pervaded the treatment of the poor is, by the Commission's recommendations, to be changed root and branch, and instead of the old exhibition of man's inhumanity to man, we are to have an intelligent differentiation between the deserving poor and the "waster." The first is to be treated as an unfortunate citizen; the latter as a danger to society. Committees of the borough and county councils will be charged with the administration of the service necessary for catering for each class, and while the weak-minded, the epileptic, the unfortunate, and others of similar type will be treated with discriminating tenderness, the incorrigible vagabond will be subjected to discipline which will make him anxious to reform his ways and become a useful member of society. Tempting as it is to dwell on these aspects of this fascinating but complicated subject, we must leave them to consider the more immediately medical problems and the ways in which they are dealt with. Here we mark considerable, perhaps the most considerable, divergence between the majority and minority reports. It is to the credit, rather than otherwise, of the British Medical Association to say that it has "captured" the majority, just as it is to the credit of the Socialists to say that they have succeeded in influencing the minority in the direction they believe to be best. In much that is to be found in the latter division of the report we fancy we trace the hand of an eminent Fabian to whom medical matters are as interesting as the drama. The view of the majority is that the "Public Assistance" Committee of the Councilit is curious that the Commissioners could not originate a description for the new authority, instead of adopting one holus-bolus from the French -should, as regards medical aid, be a kind of King Edward VII. Fund, which should take things as they find them, co-ordinate and level-up institutions for medical relief, and procure a kind of rationale in the methods and ways of hospitals. To this is to be added the duty of organising, or reorganising where it at present exists, a medical service for the poor, where possible, on a provident basis, and, when impossible, the same basis, plus financial assistance from the public funds to meet the case of those unable to pay. What is especially praiseworthy about the scheme, in its latter aspect, is that all practitioners in a locality should be, if they so wish it, available as menibers of the staff of the provident dispensary, and what is, perhaps, a little odd in the case of a State document, is that the British Medical Association is to be the authority to determine the scale of fees and the wage-limit to be applied to members of the dispensary. We can imagine the criticism likely to be applied to such a proposal if made in Parliament by a certain type of "working-man's friend," who lives by vilifying medicine and medical men; but for the British Medical Association itself it is certainly a sign of influence which we will not begrudge it. To our mind, perhaps, the most important point in this part of the document is the recognition of the fact that a citizen must pay the expense of his doctor, and, if unable to do so, the liability lies on the State. At any rate, these proposals are not yet law! The minority report is essentially socialistic in its tendency, and, like all socialistic doctrines, it is admirable in theory, but, alas! extremely difficult to conceive of as practicable this side of the Millennium. The ideal aimed at is the co-ordination of all medical services in one public health service, which shall be primarily preventive in its character, and only incidentally curative. In fact, the curative side is only, it would seem, to apply to those unlucky, or, rather, wrong-headed, individuals who insist on neglecting the admirable precautions designed for them by the preventive service, and so fall into sickness. Our own view emphatically is that the medical officer of health is not the officer to control or be associated with curative medicine. He has his own important and responsible duties, and they are amply sufficient for the energies of the ablest and most energetic of men.

#### CURRENT T PICS.

Medical Inspection of School Children. THE logical nature of the medical inspection of school children is every day becoming more apparent. If the nation is to be physically regenerated on scientific lines, it is obvious that one of the most essential steps will be to detect and, as far as may be, eliminate the defects of the juvenile population. A good illustration of what may be done in this direction may be taken from the recentlyissued report presented by Dr. D. Ll. Williams and Dr. Katherine Drinkwater to the Wrexham Education Committee:—" Up to the end of the year 1,142 children had been examined out of 3,083 on the books. Decayed teeth were found in 761-considerably more than half of the number-and it was regretted that more use was not made of the toothbrush. There were 207 cases of simple enlargement of the tonsils and of overgrowth of the lymphoid tissue in the post-nasal region, known as adenoids. There were 96 children found to be suffering more or less from defective sight, but only 12 from defective hearing; 28 were poorly nourished and under-developed, 75 were suffering from uncleanliness of the head or body, 36 were poorly and inadequately clothed, and in 47 instances the boots were very defective. There were 35 cases of enlarged glands, 35 cases of some form of skin disease, 18 children exhibited some deformity or defect in their constitutions, 29 suffered from heart affections, and 25 from diseases of the lung." regards the treatment of the children. Dr. Williams thinks it would be unwise to trespass on the sphere of the medical practitioner, their cooperation in this work being most essential. It would be quite impossible in regard to the majority of the ailments and defects to persuade or insist upon the parents obtaining proper treatment.

#### The Small-Waisted Woman.

An enterprising lay contemporary, The Tatler, has succeeded in infusing fresh interest into that time-worn subject, tight-lacing. Some time back that journal published a photograph of a famous Parisienne under the sensational title of "the smallest waist in the world." As might have been expected, this challenge was not permitted to pass unanswered, and society has now been enlivened by an article from the same source, asking, "Who has the smallest waist?" Some of the illustrations reveal depths of abysmal foolishness which the small-footed Chinawoman would probably regard with almond-eyed contempt. One lady, "tall and Junoesque," wears a 12-inch metal waist-belt, "an invention of her husband." Happily, few men concern themselves with so criminal a folly; indeed, the majority have no admiration for the tight-laced woman, whose anæmia, indigestion and generally disorganised organic functions render her anything but an attractive being from the male point of view. Another lady is shown in bathing dress, about to take her morning dip in 15-inch corsets. We presume this is the sort of misguided fanatic who would sleep in her "stays," to use the old-fashioned name for this feminine abomination. Another distorted figure is that of a Belgian schoolgirl with a wasp waist, and another older girl who wears a 13-inch corset with ease." Whatever this lady may do during the few elastic years of her youth, it is certain, if she continues to indulge in the practice, she will do so with disease predominant, especially as she elects to throw her whole body out of gear by the use of 41-inch heels! One correspondent of *The Tatler* boasts that her little daughters have worn 15-inch corsets for some time. It would be well, in our opinion, for the lady suffragettes to turn their attention to this matter of small waists, which is of supreme importance to the future position of their sex. Women can hardly hope ever to approach an equality with man while she handicaps herself with the absurdities of feminine dress of the present day, let alone the grotesque fashion of tight-lacing, whereby the natural outlines and natural functions of the body are alike thrown out of balance.

#### The Sale of Poisons.

At a recent prosecution of a London chemist for unlawfully selling prussic acid to a customer without first obtaining his signature in the poison-book, it appeared that the poison was sold by the qualified assistant in charge of the shop to the person in question, who later committed suicide. The sale was noted in the poison-book, though the name of the purchaser was not his real name, and no signature was appended. It appeared that the deceased told the manager of the shop that he wanted the drug to kill his father's dog. For defendant it was urged that a purely technical offence had been committed, and was a matter very different from a wanton infringement of the Act. The Pharmaceutical Society, however, pressed for a conviction, and the magistrate inflicted the maximum penalty of £5, with £25 5s. costs. Laxity of the kind shown in this case demands drastic treatment in the interests of the public. It seems almost incredible that responsible pharmaceutical chemists should run the risks entailed in the neglect of statutory precautions formally and deliberately laid down by Act of Parliament.

#### Parasitic Diseases in Children.

THE crying need of some systematic method of dealing with parasitic diseases in children has long been recognised, and it is not a little curious that in these days of enlightened philanthropy the practical outcome has hitherto been small and ineffectual. All who are acquainted with the facts of out-patient hospital practice in all parts of the kingdom know that many of the children brought thither are affected with ringworm and various forms of pediculosis. The attempt to deal with these complaints in the out-patient department is rarely satisfactory. The cure of ringworm demands patience, care and thoroughness that it is in most cases impossible to procure in the homes of the poor. Under modern methods ringworm has been rendered a much more tractable disease than formerly, but the highly skilled and technical treatment entailed is beyond the resources of the ordinary hospital. School children are brought to the voluntary hospitals to have their ringworm diagnosed and treated, and the school authorities demand unpaid certificates from the honorary medical staff. A more just recognition of the relations of hospitals to public authorities would suggest that if education committees want services of this kind, they should be prepared to pay for them. Then, again, the treatment of pediculosis capitis vel corporis in out-patient departments is far from satisfactory. It is easy enough, as a rule, to destroy the parasites and ovain any given case; it is another and very different matter, however, to avoid the risks of re-infection, because of the absolute hopelessness of securing a proper disinfection of the patient's home environment. On many grounds this question is deserving of close attention on the part of all concerned. Its proper solution can be arrived at only by the intelligent co-operation of voluntary hospitals, education boards and local authorities. A necessary preliminary to that desirable consummation would be an authoritative inquiry into this somewhat complicated problem.

#### The Cancer Mortality.

THE REGISTRAR-GENERAL'S Annual Returns serve an extremely useful purpose by reminding us periodically of the limitations of our knowledge. Although 30,000 die annually of cancer, scientific medicine has hitherto discovered no cause for the malady, nay, more, it cannot be said to have formulated any theory upon the subject that will hold water. An enormous amount of good work has been done, but the results have not been, so far, positive. Many promising lines of research have been opened up, and at any moment, the great discovery may be lighted upon in some bye-path. If it might be permitted to make the remark, the special research organisations, in spite of the fine character of their scientific work, might perhaps gain in breadth were they a little more catholic in their attitude tó outside investigators. Some time ago it was the fashion to scoff at Dr. Doven's bacillus neoformans, but we believe that organism is now recognised by our leading English authorities as invariably associated, in a parasitic sense, with cancer. It is interesting to note that Mr. Samuel Whitchead, in endowing some cancer beds at Middlesex Hospital, in 1792, wrote: "I take the liberty to observe that two principal objects present themselves to my mind on this occasion, namely, the relief of persons suffering under this disease and the investigation of a complaint which, though extremely common, is, both with regard to its natural history and its cure, but imperfectly known." It is interesting to note how imperfect our knowledge on the point still remains after the lapse of 116 years.

#### The Rise of Rhubarb.

The origin of drug taking for remedial purposes is lost in the mists of prehistoric antiquity. Possibly or probably it began at some stage of the world's progress long before that all-important event, the evolution of the genus homo, took place. It is a well-known fact that various lower animals use herbs medicinally; for instance, dogs eat grass. and deer and buffaloes will travel enormous distances to get salt, presumably for therapeutic purposes. So far as man is concerned, it is interesting to learn from the evidence of early Chinese records that rhubarb was an article of commerce 2,700 years before the Christian era. That fact is vouched for by Mr. Harwood Lescher, who recently delivered a learned lecture on the subject. An interesting field of speculation is opened up in this way. It is known that herbivora avoid certain plants by what we usually call "instinct," but is probably the crystallised outcome of prolonged observation. Indeed, it is a matter of surprise that cattle eat yew leaves now and then, and so get poisoned. The wonder here to the man in the street is clearly why a cow has not learnt that yew leaves are deadly. On the whole, it seems not unlikely that the stomachic virtues of rhubarb were known to man at a period compared to which ancient Chinese history is as yesterday.

#### The Radium Institute.

THE announcement a few weeks ago of the foundation of a "Radium Institute" was made with considerable noise, and many of the lay papers hailed the occurrence as the start of a new era in surgery. In this they were only following the lead of a distinguished surgeon, who since his retirement from practice seems to have abandoned much of his erstwhile professional caution. Many medical men are asking themselves what is to be the relation of this much-vaunted institute to medical practice, and Mr. Hall-Edwards, in a letter to a contemporary, sounds a necessary note of warning. It would appear, from the vague statements made, that the Institute is to apply radium to surgical purposes, and to charge suitable fees to those who can afford them. If this is so, then it would appear that an attempt is being made to create a monopoly for the treatment of certain diseases, the monopoly being in the hands of a trust possessed of large funds, and an amount of patronage which makes it all-powerful. If this be really what the Institute is, it is the duty of the profession to speak out clearly its disapproval of the scheme. An enterprise of this kind should be in the form of a medical charity for the benefit of persons of small means. To use funds given for charitable endowment for the purpose of making money in fees is to alienate the purpose of the endowment, and to add yet another to the many forms of competition which medical men, consultant and otherwise, are called upon to face. The straits into which the medical profession have been driven are to a large extent attributable to the unthinking kindness of goodnatured folk who pour money like water into the coffers of the medical charities, but take no heed of the way in which it is spent. While appreciating to the utmost the conspicuous humanity that has prompted the foundation of the Radium Institute, we trust that sufficient wisdom will be instilled into its counsels to enable it to steer clear of injury to the interests of medical practitioners. Why should not representatives of all branches of the medical profession, consultant and otherwise, sit on the executive of the Institute?

#### PERSONAL.

THE PRINCE AND PRINCESS OF WALES, accompanied by Sir Frederick Treves, paid a visit to the London Hospital on Saturday afternoon last. Their Royal Highnesses visited the out-patients' department and the new hot-air bath, and inspected the drug department and the various wards. They also entered the medical college, and witnessed a number of experiments by the professors.

PRINCESS VICTORIA OF SCHLESWIG-HOLSTEIN opened the new wards for children at the Royal Portsmouth Hospital, on February 3rd. The Princess declared the wards open, naming them "The Edward and Mary," after Prince Edward and Princess Mary of Wales, and

"The Young Ward," after the Chairman of the Building Committee. The hospital was then inspected, and after taking tea in the upper new ward the Princess left for Admiralty House.

THE University of Edinburgh have offered the honorary LL.D. degree to Sir Alfred Keogh, K.C.B., Director-General of the Army Medical Corps.

PROFESSOR DIEUDONNE, who went to India in 1897 to investigate the plague epidemic as a member of Professor Koch's Commission, has been appointed "Referent" for the kingdom of Bavaria in succession to Dr. von Grashey, who is retiring.

Mr. S. A. Ballantyne, M.B., Ch.B.Ed., F.R.C.S. Ed., has been appointed Honorary Surgeon to the Coventry and Warwickshire Hospital.

LAST week a handsome presentation was made to Dr. Midwinter, of Anerley, of a testimonial upon the conclusion of a long practice in this district.

Dr. L. NICHOLLS, of the Colonial Civil Service, has been appointed District Medical Officer, Bacteriologist, and Lecturer on Sanitation in St. Lucia, West Indies.

The trustees of the bequest of the late Mr. James Dick have allocated more than £311,000 to charities in different parts of Scotland. The Victoria and the Western Infirmaries at Glasgow receive £30,000 each.

THE University of Cambridge have appointed Dr. W. H. R. Rivers, University Lecturer in Experimental Psychology, to represent the University at the celevation in July next of the fiftieth anniversary of the foundation of the Anthropological Society of Paris.

The late Mr. J. A. D. Shipley, of Newcastle, left the residue of his estate, which, after paying various bequests, is estimated at about £100,000, for division among various local charities, including the Royal Victoria Infirmary and other medical charities.

THE annual general Court of Governors of the Charing Cross Hospital was held in the board-room on February 18th, under the chairmanship of the Earl of Kilmorey, K.P., who is retiring from that position in March, when he will be succeeded by Viscount Ridley.

DR. F. W. HEWITT, M.V.O., who holds the position of Anæsthetist to His Majesty the King, gave evidence on February 10th before the committee which is now sitting, under the chairmanship of Sir Mackenzie Chalmers, K.C.B., to inquire into the law relating to coroners and coroners' inquests.

PROFESSOR CHARLES, M.D., F.R.U.I., D.Sc., F.R.S.E., late Professor of Anatomy and Physiology in the Royal University of Ireland, has lately presented a gold medal to be annually competed for by the anatomy and physiology classes alternately in memory of his eldest son, Captain G. E. Charles, I.M.S., whose early death cut short a most brilliant career.

WE regret to learn of the resignation by Mr. Alban H. G. Doran, F.R.C.S., of his position as Senior Surgeon to the Samaritan (Free) Hospital for Women, Marylebone Road. In recognition of his services to the hospital, the Committee of Management have decided to hold a complimentary dinner at the Imperial Restaurant on March 9th.

SPECIAL terms for travelling expenses and hotel accommodation for those who wish to attend the International Congress of Ophthalmology, which will be held at Naples from March 2nd to April 7th, are being arranged. Anyone wishing to attend should make early application to one of the corresponding members for this country: Mr. Walter H. Jessop, 73 Harley Street, London, W.; Dr. George Mackay, 20 Drumsheugh Gardens, Edinburgh; and Sir Henry Swanzy, 23 Merrion Square, Dublin.

#### A CLINICAL LECTURE

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#### UNCOMMON TYPES OF COMMON DISEASES.

By JAMES ALEXANDER LINDSAY, M.D., F.R.C.P.Lond.,

Professor of Medicine, Queen's University, Belfast.

When face to face with a difficult problem in diagnosis we shall do well to remind ourselves that we are much more likely to be dealing with an uncommon type of a common disease than with a rare disease—properly so-called. Rare diseases are rare—let us hold fast to that obvious, but not unfruitful, truism. Uncommon types of common diseases are not rare, and are a fruitful source of difficulty and error in diagnosis. We are all too apt to regard diseases as well-defined and distinct entities (an error which the clear-cut descriptions of text-books do much to perpetuate), instead of being the every varying response of very different organisms to some disturbing influence, whether toxic or otherwise. We are accustomed to the maxim, a true one in the main, "we must treat the patient and not the disease." We are less accustomed to the habit of mind of studying the diseased individual rather than the disease. We must avoid making an abstraction of a condition of which we know nothing apart from its manifestations in the individual.

Instead of being a matter of surprise that disease should vary within wide limits, it is, in fact, just what we might expect. Age, sex, habits, heredity, race, previous diseases, social militum, diet, and other conditions modify, often to an essential extent, the response of the organism to disease. We have many books upon "Children's Diseases," but, as a matter of fact, the diseases absolutely limited to childhood are few in number. What the writers are really concerned with is "Disease in Children." Age may be the most potent element in prognosis—as in pneumonia. A faulty, nervous heredity may impart a grave significance to apparently trifling sources of irritation. The dose and virulence of a toxin, the state of health of the individual at the time of infection, the promptitude or slackness with which the early manifestations are dealt with—these, and many other factors which need not be considered in detail, explain why disease presents an ever-varying picture, so variable, indeed, that only an extended experience and an open mind can preserve us from serious error. Our conceptions of disease must not become stereotyped or fossilised.

I propose to take a few of the common diseases and briefly advert to some of the more striking departures from types which have come under my own personal observation. Some of these, no doubt, will be familiar to many, if not most of my readers. Let us take the following conditions, and the list might be easily extended:—

Pneumonia, Typhoid fever, Scarlatina, Pulmonary phthisis, Aneurysm, Gastric ulcer, Pernicious anæmia, Cerebral tumour.

#### 1.—PNEUMONIA.

Pneumonia is the type of a sthenic disease, of an acute infection, and probably no disease is, on the whole, more uniform in its manifestations. The sudden onset, the initial rigor, the marked dyspnæa, the altered pulse-respiration rate, the characteristic sputum, the peculiar pyrexial curve, the obvious physical signs in the lungs these are highly significant and, on the whole, remarkably constant. Yet striking exceptions occur. I have seen several cases of pneumonia where the temperature remained normal throughout, or only rose slightly a few hours before death. I

have seen a case, an elderly patient, where death took place within twelve hours of the initial rigor. In another case, a child of 7, the crisis did not occur until the 20th day the delay being apparently due to successive invasions of fresh lung tissue, the secondary attacks overlapping the primary one. I have seen a good many cases where the onset was spread over three or four days, the early symptoms being vague, and the early physical signs being either quite vague or simply a small patch of limited crepitus at one base. These cases are commonly put down as "influenza fol-lowed by pneumonia," but there can be little doubt that many of them are pneumonic from the outset. Cases of pneumonia ephemeris are often misinterpreted. In this condition the attack sets in with characteristic symptoms and signs, but comes to an abrupt termination in two or three days, the verdict often being "only a severe cold." But a severe cold does not involve a very sudden seizure, marked physical prostration, and perhaps a spit or two of red material—features which may often be detected in pneumonia ephemeris. I need hardly say that pneumonia sometimes sets in with a clinical syndrome resembling that of meningitis-intinical syndrome resembling that of meningits—intense headache, convulsions, coma—which is one of the well-known pitfalls of the unwary practitioner. A glance at the alæ nasi, and an adequate examination of the chest will keep us right in this matter. The latency of the physical signs in the early days of pneumonia is a well-known source of difficulty. I have known a case where with typical onset and characteristic symptoms nothing could be discovered in the chest until the fourth day.

#### 2.—TYPHOID FEVER.

Unlike pneumonia, typhoid fever is a protean disease—its manifestations are highly variable. There is hardly a symptom in the clinical syndrome which is not occasionally absent. I have not chanced to see a non-pyiexial case, but such cases are recorded. I have seen a case with a sharp sthenic onset, leading to apprehensions of typhus. I have seen a well-marked meningeal onset in a child, which presented the features of retraction of the head, squint and coma, but the character of the stools and the course of the case soon made the diagnosis clear. I have seen a case where, by successive relapses, without any obvious complication, the pyrexial period was prolonged into the twelfth week, the patient ultimately making an excellent recevery. I have known the initial severe frontal head ache—a symptom of considerable diagnostic value—to be entirely absent. I have known the bowels to act normally throughout the attack. I have known the tongue to remain clean until the disease was well developed. I have known a patient to die suddenly from profuse intestinal hæmorrhage, in whom, a few hours before death, the abdomen was slack, free from distension, pain, or tenderness, and where the pulse was good. Such cases are a wholesome reminder of the need for caution in prognosis in typhoid fever. Some cases which have been diagnosed "typhoid fever. Some cases which have been diagnosed "typhoid fever. Some cases which have been diagnosed "typhoid fever. Some cases which have been diagnosed the outset, and the distinction is often difficult and may be even impossible. The practitioner may get a hint by watching the tongue—uniformly furred in tuberculosis, red at the tin and edges in typhoid; by attention to the skin—almost always moist in tuberculosis, variable and sometimes dry in typhoid; by noting the pulse—more frequent in tuberculosis in proportion to the temperature, dicrotic in typhoid; by watching the

temperature, the abdomen, the lungs, and by Widal's reaction. This reaction is found in about 90 per cent. of cases of typhoid. It is occasionally found in other conditions, such as typhus fever and cerebro-spinal meningitis. The reaction is, therefore, not specific.

#### 3.—SCARLATINA.

The diagnosis of mild and uncharacteristic cases of scarlatina is one of the most difficult tasks in medical practice, and, with the utmost care and circumspection, we must expect to be occasionally deceived. The disease has no constant features. Highly characteristic in a typical case as are the conditions of skin, throat, tongue, pulse, temperature, etc., these may all fail us or leave us in doubt. I remember a case which occurred in my practice many years ago. I was called to see a little girl who was covered from head to throat with a profuse scarlet rash. But the temperature was normal, the pulse not accelerated, the tongue clean, and the little patient was playing with her toys, calling out for food, and wondering why she was being kept in bed and on a milk diet. I expressed the opinion that the case was probably not scarlatina. I was mistaken, however, as the further development of the case clearly proved.

In most cases of even very mild scarlatina we get a hint, if we have the intelligence to take it. The onset is nearly always more abrupt than would be probable in any alternative view of the case. The child very often vomits once or twice, even in slight cases. The pulse nearly always shows marked acceleration—a point upon which a good deal of reliance may be placed. Faucial symptoms occur early, are very seldom entirely absent, but may be very slight, and the patient may not complain of them at all.

#### 4.—PULMONARY PHTHISIS.

A whole lecture might easily be devoted to the variations in pulmonary phthisis and the diagnostic pitfalls which have to be avoided. The sputum should, of course, always be examined when it can be obtained. The presence of tubercle bacilli is decisive, that of elastic tissue hardly less so. In many cases, however, there is no sputum, or it cannot be obtained.

A robust physique and a well-developed thorax are no certain protection against tubercular infection. I have met the disease not infrequently in persons who might have been thought à priori to be most unlikely subjects of invasion. Further, the disease may find a lodgment, and even make considerable progress, without either pyrexia or loss of flesh. This statement may be challenged, but the evidence on the subject is really decisive. The thermometer and the weighing machine are of inestimable value in doubtful cases, but the information which they afford is not in all cases conclusive. In medicine, we must not reason from negatives. In the present case it is not safe to say to a patient—"You are not feverish, and you have not lost weight; therefore you have not got phthisis."

The physical signs of commencing phthisis are in not a few cases equivocal. We look for, and we generally find, some localisation of signs at one apex, some impairment of expansion, some muffling of percussion resonance, some harshness or feebleness of breath sounds, some increase of vocal fremitus and vocal resonance. But the condition may be quite different from the above familiar clinical picture. The signs may be those of pleurisy, or bronchitis, or pneumonia, while tuberculosis is really the primary fact. The fact that pleurisy is often tubercular, or a precursor of pulmonary phthisis, is now well known, and the more we study the subject the closer will this connection appear to be, but we must not adopt the extreme view that all pleurisies are tubercular. Pleurisy can be excited by many micro-organisms and the rôle of the pneumococcus is possibly hardly less influential than that of the tubercle bacillus. It is less generally recognised that pulmonary phthisis may set in with physical signs not immediately distinguishable from those of bronchitis, but of this fact I have had conclusive evidence in my practice. No doubt, the resemblance of the conditions is only temporary. Before many days or weeks have passed the bronchitic rales become metallic or crepitant, they tend to become more or less localised, the breathing and the percussion note undergo significant changes. Pneumonic phthisis may closely simulate pneumonia, the physical signs of the two conditions being for a time identical, but error may be escaped by attention to the mode of onset, the course of the temperature, and the characters of the sputum.

A chronic fibroid tuberculosis of one upper lobe, with emphysema of the adjacent portions of lung, may produce a clinical syndrome closely resembling that of asthma, and error is all the more likely inasmuch as the association of asthma and tuberculosis is a rare one. The following clinical rule will be found useful:—In a case clinically resembling asthma, where the patient is young, below normal weight and of poor physique, consider the possibility of fibroid tuberculosis, examine the apices with special care, inquire into history, especially the occurrence of hæmoptysis; examine the sputum.

5.—ANEURYSM.

The clinical picture of fully-developed thoracic aneurysm is usually characteristic, and diagnosis is obvious, but the difficulties of diagnosis at an early stage of the disease are often great. The patient may complain only of a vague feeling of oppression or discomfort in the chest, and physical examination may be negative; or a teasing cough, an unexplained hæmoptysis, a persistent hoarseness, or a quasi-asthmatic seizure may be the first symptom. Many of these cases are misinterpreted and subjected to a futile course of treatment, directed to a supposed lesion of the larynx or lungs. If we carefully keep before our minds in such cases the possibility of aneurysm, our difficulties will be lightened and a more or less probable diagnosis may be made. The subject of thoracic aneurysm is in most cases a male at or about middle life, in the great majority of cases there is a history of syphilis, the general state of nutrition is often good, there is frequently evidence of premature vascular degeneration, careful percussion of the upper part of the thorax will often reveal an area of dulness, the pupils may be unequal, tracheal tugging may be recognised, and so on. It is probable that once on the track of an aneurysm we may be able to discover it.

The danger is that we may be wholly misled by uncharacteristic symptoms. It is a good clinical rule-In the presence of obscure thoracic symptoms do not forget to weigh carefully the possibility of aneurysm.'

#### 6.—GASTRIC ULCER.

In the presence of a painful dyspepsia the possibility of gastric ulcer will always naturally come in for consideration. In a large proportion of cases we find the following syndrome: Pain of a somewhat intense character, located in the epigastric or submammary regions, or in the back, coming on twenty minutes or half-an-hour or more after food, much affected by the character of the diet, relieved by vomiting; a small area of well-defined tenderness in the epigastrium; occasional vomiting, with or without blood; a condition of hyper-acidity of the gastric contents. Age, sex, and the presence of anæmia may assist the diagnosis. Hæmatemesis is often decisive, but we must bear in mind Hale White's teaching that a good many of these cases are gastrostaxis, and not ulcer. What is even more important is the fact that hæmorrhage is often absent in cases of undoubted ulcer—perhaps in nearly half the total number.

Difficulties of diagnosis may arise as follows:—The pain may be uncharacteristic. It may be relieved by taking food, though I believe this to be very rare in gastric ulcer, while it is the rule in duodenal ulcer. There may be no vomiting and no hæmatemesis. The patient may be a young and obviously neurotic female, and the difficulty of excluding gastralgia may be considerable. I suggest the following rules: Severe persistent gastric pain in a young woman is far more likely to be due to ulcer than to gastralgia. This latter condition is somewhat rare. The pain of ulcer is more constant day by day, more consistent, more closely related to the ingestion of food, more definitely relieved by vomiting. The area of epigastric tenderness is rarely absent in ulcer. It requires deep pressure to bring it out, while in gastralgia the hyperæsthesia

seems to be superficial, and pain is caused even by a light touch. The hyperacidity of the gastric contents in ulcer is almost constant. In gastralgia the patient sometimes complains of as much pain after a few mouthfuls of water as after a beefsteak. This never occurs in ulcer.

Painful dyspepsia, due, not to neurosis, but to flatulent dyspepsia or hyperacidity, is usually easily recognised, and can be readily controlled by regulation of the diet and appropriate medicines. Its comparative amenability to treatment—dietetic and medicinal—helps to distinguish it from ulcer and gastralgia.

7.—PERNICIOUS ANÆMIA.

That, after excluding all cases of profound anæmia due to hæmorrhage, malignant disease, pregnancy, intestinal parasites, renal disease, and some other conditions, there remains a group of cases to which the term of essential or pernicious anæmia may be fairly applied, is the opinion of the majority of clinical observers; but the subject is still involved in great obscurity. That pernicious anæmia can be distinguished from profound secondary anæmias by the blood examination alone is a most doubtful proposition. Most observers have seen cases where the blood presented the "pernicious type," but where the subsequent development of the case provd that some one of the above enumerated causes of severe anæmia was the true explanation. Malignant disease is the most frequent source of error. Two cases stand out in my recollection where the blood examination favoured the diagnosis of pernicious anæmia. One died a few years later of uræmic coma; the other was found at the autopsy to be the subject of malignant disease of the small intestine. It is well to accept pernicious anæmia as a provisional, rather than a substantive, diagnosis, to search carefully for a primary cause for the anæmia, and to bear in mind that only time and a careful diagnosis by exclusion justify the acceptance of pernicious anæmia as a final diagnosis. It seems probable that pernicious anæmia, understood in this restricted sense, is not a distinct entity with a definite causation and pathology, but rather the late result of various causes of profound hæmolysis, just as "arthritis deformans" is probably not a definite pathological entity, but a late and profound disorganisation of joints depending on the operation of several toxins

8.—CEREBRAL TUMOUR. Every student knows the classical signs of cerebral tumour—headache, vomiting, double optic neuritis, convulsive seizure. If every case presented these signs in typical form and in combination, the labour of diagnosis would be, indeed, light. Unhappily, untypical cases are common—perhaps nearly as common as typical cases. In a recent case in my own experience almost the only complaint of the patient was of loss of vision in one eye; yet the autopsv revealed the presence of a large cerebral tumour. In other cases vague and persistent headache, not always severe, is almost the only symptom, until some day a convulsion suggests the real root of the mischief. In yet another type of case the patient undergoes a process of mental and moral deterioration. He becomes neglectful of his work, his memory is impaired, and he becomes morose or irritable. Our suspicions may turn in the direction of general paralysis of the insane or some other form of dementia, while the real mischief is a cerebral tumour.

I might easily give further instances of "Uncommon Types of Common Diseases." It would not be difficult to illustrate further the protean character of disease. Nature does not proceed on hard and fast lines. There are few of her laws which have not got their exception. It has been well said that there are two words which have no place in medicine—viz., "Always" and "Never." The moral for us is to keep out conceptions of disease flexible and fluid. to guard against hard-and-fast rules and stereotyped ideas, to be careful not to argue much from negatives, to be vigilant in diagnosis, and to be always ready to reconsider our views in the light of fresh evidence.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Felix Mendel, M.D., Beenn (Ruhr.). Subject: "The Present Position of Intravenous Treatment."

#### ORIGINAL PAPERS.

A SHORT CRITICISM OF

#### RADICAL OPERATIONS FOR THE CURE OF BACKWARD DISPLACE-MENTS OF THE UTERUS. (a)

By HENRY JELLETT, M.D., F.R.C.P.I.,

Gynmocologist and Obstetric Physician to Dr. Steeven's Hospital.

Dublin.

EVER since the first systematic practice of gynæcology began the non-gynæcological mind, both lay and medical, has considered a gynæcologist as a person whose principal duty it is to insert pessaries, and who does so on every available occasion. It is probable that in the past there has been some justification for this belief, because there were but few alternative measures which could be adopted with safety for the relief of one of the most frequent class of female ailments, namely, uterine displacements. Gynæcological practices have, however, widely changed during the past ten years, and though it is not possible to banish at present the pessary, the majority of gynæcologists no longer regard it as affording the best method of treating uterine displacements, but rather as an ancillary method which one may be forced to use by the special circumstances of the case. This change has come about with comparative rapidity. When I was assistant at the Rotunda between ten and thirteen years ago, I think I am right in saying that the general practice was only to perform radical operation for the cure of backward displacements in exceptional cases. In such cases the operation was usually performed by the vagina, and took the form of Mackenradt's or Dührssen's vaginal fixation of the uterus. These operations, however, came to be regarded as likely to be dangerous during pregnancy and labour, and consequently their use was limited to cases in which the patient had passed the childbearing period.

Five years ago one's views on radical operations had advanced a stage, and many gynæcologists considered that such operations should be performed if there was any difficulty either in fitting a suitable pessary or in having it looked after subsequently. My own practice in hospital was that, if a patient who lived in Dublin came to me with a backward displacement, I put in a pessary, but if she came from the country, or was a soldier's wife and likely to leave Dublin. I did a radical operation. Most operators, I think, preferred in such cases Howard Kelly's operation of ventral suspension of the uterus.

From this stage it is only a short step to the views which are held by some operators at present, and with which I personally agree, namely, that if a woman is suffering from a displacement which requires relief, a radical operation should always be performed in preference to inserting a pessary, unless there are any special circumstances which make operations of any kind inadvisable. My own practice is this:—If a patient has to be curetted, or to have any other minor gynæcological operation performed, and if she has a backward displacement of the uterus I always operate on the displacement at the same time. The same rule applies even more strongly in the case of major gynæcological operations, with the exception of hysterectomy. In these cases, however, the radical cure of a backward displacement can hardly be regarded as a distinct operation, seeing that it consists merely in inserting the peritoneal sutures in a particular way.

There are, of course, exceptions to this rule. I have mentioned above one group of exceptions, namely, when operative procedures are contra-indicated by the condition of the patient. The only other exception which occurs to me at the moment is in cases of puerperal or nost-puerperal displacements, as they can usually be cured by a very temporary use of a pessary. I do not think that it is necessary for me to dwell

(a) Paper read before the Obstetrical Section of the Royal Academy of Medicine in Ireland, on January 29th, 1909. further trouble.

at any great length on the reasons for adopting this practice. No one, I think, will deny that, provided operative procedures are safe and give a good afterresult, they are preferable to the prolonged wearing of a pessary. Assuming for a moment safety and certainty of result the position is this:—One patient is brought into hospital on account of menorrhagia. She has a backward displacement. She is curetted and a pessary is inserted. Her stay in hospital varies from a couple of days to a week. She then leaves, but has to return at least every three months to the extern department to have the pessary removed, cleaned, and replaced. No matter how well it fits, it may at any time cause irritation and discharge from the vagina. It may even cause ulceration of the vaginal walls. If a large pessary has to be used it stretches the walls, and on account of this stretching its size has probably to be increased progressively. In old age it is certain to cause even more marked discomfort.

Contrast this with the history of another patient, who comes into hospital under similar conditions, and on whom a radical operation has been performed. Her stay in hospital is from ten days to a fortnight. She leaves unaccompanied by a pessary, and, so far as the uterine displacement is concerned, there is no

The only way one can decide as to the safety and certainty of the different radical operations is by examining into their immediate and subsequent results, and it is for this reason that I wish to-night to place before you a short criticism of radical operations, and especially of the method I usually adopt in these cases and its results.

I had better begin by dividing the cases in which radical operations are necessary into three groups:—
(1) Cases in which a major operation has been per-

formed and the peritoneal cavity is opened. Cases in which the displacement is complicated

by adnexal disease.

(3) Cases of uncomplicated backward displacements. The cases in the third groups are those with which I am principally concerned, and I can dispose of the first two groups in a few words.

When an abdominal operation has been performed, such as myomectomy or operations on the appendages, I always finish the operation by performing ventro-suspension of the uterus by Kelly's method, and, if the patient is likely to have children and the operation has not taken a long time, I like to supplement it by the intra-peritoneal shortening of the round ligaments. The reason for the latter step is that the adhesions formed by Kelly's operation always tear away or stretch during pregnancy, and that there is nothing to prevent a return of the displacement after delivery, if the uterus is inclined to fall back.

When a displacement of the uterus is complicated

by adnexal disease it is necessary to open the peritoneal cavity for the treatment of the latter condition, and then these cases fall under the same rule as those in the first group.

This brings us to group three and to the question, What is the best operation for the radical cure of uncomplicated backward displacements of the uterus? There are three different classes of operation:

(a) Ventral fixation or suspension of the uterus.(b) Vaginal fixation of the uterus.

(c) Operation on the uterine ligaments.

Ventral fixation of the uterus is not permissible during the child-bearing period, because it causes too strong a bond of union between the uterus and the abdominal wall. Ventral suspension, on the other hand is always permissible. Its immediate results are uniformly good, and if the uterus and its ligaments return to a normal state, the results after pregnancy are also good. It, however, affords no support what-soever after pregnancy, because the essence of the operation is the formation of a bond of union which will tear away or elongate during pregnancy and so permit uterine development. I am aware that there is a difference of opinion on this point, and I was once told that if I could not get the uterus to remain in position after pregnancy in cases in which I had performed Kelly's operation it was because I had performed the operation wrongly. The speaker, indeed,

went so far to say that if I had in the past used only one fixation stitch I should in the future use two, and if I had used two I should in future use three. Such a remark applies very correctly to a ventral fixation, but not to the suspension operation. Howard Kelly, who originated the operation, writes thus:—
"After labour the malposition of the uterus may return. Fourteen cases upon which suspensory opera-tions have been performed at the Johns Hopkins Hospital have been examined at varying periods after labour. In nine of them the uterus was in good anteposition, while in five the ligaments had apparently broken and the uterus was again in retroposi-I have only one criticism to make on this remark, namely, that I am inclined to think that the normal position of the uterus in the nine cases was due, not to the persistence of the false ligament, but to the fact that the uterus and its true ligaments had returned to a normal condition. I have not looked up my own statistics, but I know I have had some half-dozen cases in which pregnancy has occurred after Kelly's operation, and the proportion of returns is about similar to that given by Kelly. In one case I subsequently opened the abdomen and there was no trace of the suspensory ligament. Further, I have never heard of an operator who has found a sus-pensory ligament in any case in which he opened the abdomen of a patient who had become pregnant after a Kelly's ventral-suspension.

Vaginal fixation of the uterus I, personally, do not like, and I think neither do most other gynæcologists. It is a useful substitute for ventral fixation in some cases, but not for ventral suspension. I thought at one time that the difficulty which it causes during pregnancy might be avoided by passing the fixation sutures low down on the uterus near the corporocervical junction. This practice, however, is useless when the uterus is large and the vagina lax, as it means that the upper part of the vagina is dragged over by the heavy uterus and the displacement recurs,

even though the fixation persists.

The third class of operations-namely, operations on uterine ligaments-includes the operation which I think is that of choice in uncomplicated displacements of the uterus. I will not weary you by discussing all the different forms of operation which have been suggested on these ligaments, their name is legion. The sacroiliac ligaments have been shortened through the vagina and through the abdominal cavity, and the practice is often a useful one in severe cases of prolapse. The round ligaments have been shortened at the external abdominal ring, and intra-peritoneally, through single incisions and through double incisions. They have been tied in knots in front of the uterus and behind the uterus. They have been pulled through openings in the abdominal wall and through openings in the vagina. Still, when every possible commutation and permutation of the original operation has been adopted, we are brought back, I think, to where we started, and to the fact that the original operation is the best and

The original operation for the shortening of the round ligaments was first placed on its present basis by Alexander, of Liverpool, and is now known by his name. It is said to have been introduced by Alquié, of Montpellier, in 1840, who, however, only performed it on animals. It was condemned by a Commission appointed by the French Académie de Médecine, and apparently died. In 1864 it was performed for the first time on a human being by Deneffe, and in 1881 it was again introduced by Alexander, to whom the credit of its existence as a well-recognised operation is undoubtedly due. In 1882 it was performed by Adams, who had previously practised it on the cadaver, and had taught it to his class. Owing to the multiplicity of parentage it is consequently sometimes known as the Alquié-Alexander-Adams operation.

As is well known, the operation consists in drawing out the round ligaments at the external abdominal ring, cutting off the excess, and anchoring the stump to the pillars of the ring or the sides of the inguinal canal if the latter has been opened. As an operation it has had a chequered career, not the least curious feature of which is its almost complete rejection by the coun-

tries in which it was originated. Not alone did the French Commission condemn it in 1840, but it was almost universally rejected by English gynæcologists after Alexander introduced it. Gradually it established a firm position in America, and now it is recognised by gynæcologists all over the world, with a few exceptions, as being a valuable operation.

Even at the present day, however, it has the virtue of causing an extraordinary difference of opinion on points which one would have thought impossible.

In a work on gynæcology published in 1907, Herman writes that "the grave objection to Alexander's operation is its risk; the danger to life and the danger of a long illness with suppuration of the wound. . . This detachment (of the ligaments), together with the tension which is put upon them, seems to lower their resisting power and make them liable to inflammation. This inflammation may lead to deep suppuration, which may spread to the peritoneum, and thus fatal peritonitis follow in a week or so after the operation."

In a similar work published in 1903, Galabin writes In a similar work published in 1903, Galabin writes that "the operation has a particular liability to be followed by suppuration of the wound." On the other hand, Noble, in 1907, states that "the mortality of Alexander's operation is practically nil. In my experience there have been no deaths"; and Taylor, of Birmingham, in the same year recorded 85 cases without a death in a paper which may be taken as a practical answer to Herman's statement that in England he "knew of no operator, except Dr. Alexander, who has performed the operation often enough to make his experience representative of the average results in the

perience representative of the acting hands of a competent operator."

So much for the objections to the operation on the ground of safety. On the ground of efficiency, so far as I am aware, there is no difference of opinion. Even those who say that it is dangerous admit that it is efficacious. All Taylor's cases were successful. Peterson operated 56 times, with no relapses that he knows of. Noble had one failure and one partial failure in about 200 cases. I will give my own statistics later.

A third objection which may be raised is that of difficulty. It is an undoubted fact that in some cases it is hard to find the ligaments, and that in others they break as they are being drawn out. The number of these cases is very marked when one begins to practise the operation. It gradually lessens very considerably, but never quite disappears. Its importance is, I think, over-estimated. One first looks for the ligament at the external abdominal ring. If it cannot be found there, one opens the inguinal canal. If it cannot be found there, or if it breaks, one deepens the incision and opens the peritoneal cavity. The ligament is then found and drawn out. If we remember that of the various structures coming through the external ring the ligament

lies deepest and lowest, we shall seldom fail to find it. I have nothing to say regarding the lechnique of the operation, save that, although in most of the cases recorded below double incisions were made, I have lately adopted the single transverse incision, and I think it is quicker. There is, however, no material difference between the two. As regards the after-treatment, I differ in one point of practice from almost everyone whose opinions I have read. Taylor may be taken as voicing these opinions when he says that he inserts a pessary and usually keeps it in place for three months after the operation. On this point I have only to say that I have never yet inserted a pessary even for a week, and that I see no object in doing so. I think my statistics show, so far as a small number of cases go, that it is unnecessary.

My cases and their results may be summarised as follows:-Forty-four cases were operated on. In 39 the usual double incisions were made, and in 5 a single incision was made. There were thus 83 separate incisions, and every one of these healed by primary union. One incision subsequently suppurated sub-cutaneously owing to the fact that the subcuticular suture broke during removal and was left behind,

One patient died, but her death, which was from double croupous pneumonia, cannot, I think, be attributed to the operation. The symptoms of pneumonia appeared in one lung on the fifth day after the operation. My colleague, Dr. Hayes, very kindly looked after her for me, but, in spite of everything, the second

lung became involved, and she died on the eighth day after operation. The incisions had apparently healed normally.

In one case the uterus subsequently fell back. This was one of the first cases on which I operated, and on making the first incision on the right side I could not find the ligament. Consequently I opened the peritoneal cavity and drew the ligament out and fastened it. As, in addition to this, I had already curetted the uterus, performed a double trachelorrhaphy, and ligatured piles, the operation had lasted sufficiently long, and consequently I did not operate on the left ligament. The uterus was thus suspended by only one ligament. In spite of this, the uterus was in good position when the patient left the hospital 17 days later, and was also in good position six months later. The patient, however, returned two years later, and the displacement had recurred.

In two cases the patients were subsequently delivered under my care. On examination a fortnight or so after the delivery the uterus was found to be in a normal position.

In conclusion, I should like to state shortly why I consider that Alexander's operation is the operation of choice in uncomplicated cases of backward displacement of the uterus. To my mind the only operation which comes into competition with it is Kelly's method of ventral suspension. If there is any appreciable element of risk attachable to either operation, I think that it attaches itself more strongly to the operation which necessitates the opening of the peritoneal cavity, and that if both operations are equally suitable, the one which does not necessarily involve such an opening is the one to select. Further, I think that Alexander's operation is more likely to lead to permanent results after parturition, though I quite recognise that it is not infallible. The false ligament formed during Kelly's operation must either stretch during pregnancy or break. If it stretches it must practically extend from the symphysis to a little below the ensiform cartilage. It is only a peritoneal band, and to expect it to contract again to such dimensions as to exert a restraining influence on an unimpregnated uterus is to expect too The round ligament, on the other hand, undoubtedly possesses the power of contraction, and normally elongates during pregnancy and again returns to its former length. We can, therefore, look forward with some degree of confidence to the shortened ligament involuting after pregnancy to an extent which will again enable it to exert a restraining effect on the movements of the fundus.

The Kelly operation possesses one advantage, namely, that it enables one to inspect the uterus and pelvic organs generally during its performance, and so to make sure that there is no adnexal disease. Alexander operation, on the other hand, compels one to depend on the results of a bi-manual examination. In this respect the question becomes one of diagnosis. Alexander's operation is only suited for uncomplicated cases. If there is any doubt as to whether the case is or is not uncomplictaed, by all means give the patient the benefit of it and perform Kelly's operation. So far as my own experience goes, however, it is only in a small percentage of cases that such a doubt exists.

The difference between extra-peritoneal and intraperitoneal shortening of the ligaments is that after extra-peritoneal shortening the uterus is held by the extra-peritoneal shortening the uterus is need by the strongest proximal portion of the ligament, while after intra-peritoneal shortening the uterus is held by the weak distal portion. For this reason the former operation is much more satisfactory.

I began this paper by saying that, provided operative procedures are safe and give a good after-result, they are preferable to the prolonged wearing of a pessary. I have quoted statistics, including my own, of 385 cases, amongst which there were, so far as is known, about three failures and one death. The latter was due to croupous pneumonia, and save that it occurred after the operation had no other connection with it. I think, therefore, we may consider that Alexander's operation affords a certain and safe cure of all uncomplicated cases of backward displacement of the uncourse and that it artists and the items. of the uterus, and that it entitles us to advise opera-tion in all such cases which require treatment.

#### SHRAPNEL WOUNDS.

By Marine-Oberassistenzarzt Dr. SCHEEL.

On August 21st, 1907, at the Artillery Depôt, Wilhelmshaven, twelve men and two women were engaged in a wooden shed resting on a stone basement in emptying and cleaning 15 cm. shrapnel During the process twenty of the shells exploded, causing such injuries as would be likely to be numerous in any future war, so that the publication of the cases seems to be of general publication of the cases seems to be of general interest. Of the 14 engaged, '5 were killed outright, 3 were seriously injured, 3 slightly, and were taken to the dockyard hospital; the remaining 3 were working farther away and saved themselves by a rapid retreat. The five immediately killed had the following injuries:—(1) Workman L. From the trunk almost the whole of the anterior abdominal wall from the breast to the symphysis publis minal wall from the breast to the symphysis pubis was torn away, and from the crest of one ilium to the other. The abdominal contents, especially loops of intestines, were protruding. (2) Workman W. Almost all the anterior half of the skull and the greater part of the face as far as the upper lip were missing. Pieces of bone, remnants of brain, and blood clots lay in the opened skull. Of the left arm only a stump 20 cm. in length remained. On the right hip the skin was entirely gone from an almost circular space 20 cm. in diameter. (3) Workman W. Here was a widely gaping rent from the top of the head to the middle of the left side of the neck, 2 cm. in width, through both the soft parts and the bones of the skull, so as to admit a view into the cavity of it. Half of the brain was The face was so much torn as to be missing. unrecognisable. The right arm was torn from the shoulder-joint. On the lower part of the leg and the remains of the thigh charred remnants of bone and of the soft parts were seen lying. (4) Workman R. Right arm torn to shreds and the bone shattered. The skin was missing both over the back and the abdomen, all the deeper-lying soft parts were in shreds and the bones broken up. The vertebral column torn apart. The left lower extremity was torn from the trunk. (5) Workman F. A gaping wound 12 cm. in length was present on the outer side of the left arm, in which lacerated soft parts and fragments of the bone of the arm were visible. The right hand torn to shreds. On the right leg was a wound 10 cm, in length in which were to be seen the lacerated soft parts and the shattered stumps of the bones of the leg. On the left leg were several openings the size of tenplennig pieces, through which soft parts soaked in blood were protruding. Several shrapnel balls were lying in the exposed cavities of the bodies, in the wounds on the extremities, and in the clothing. Two women and one man were brought in seriously injured, the latter dying of his injuries six days later. They were:—(i) Workman M. The hair was singed off and there were burns on the head and face. Œdema of the eyelids. Burns on the left shoulder, the left upper and forearm and hand. The right hand and forearm were less seriously injured. (2) Workman F. (Burst out into flames at once, and had sprung immediately into a trench of dirty water near by.) The clothes dripping with mud; on removal of the clothes several blisters already burst and very much soiled The hair badly singed. Extensive were found. burns on the head, neck and face. The right arm badly burnt, the skin of the hand torn off into shreds, the bones of the index finger broken to Burns on the left arm, the chest and back. (3) Workman O. (Had at once fallen down, and had had elastic rubber bandages applied to both

thighs on account of arterial hæmorrhage.) The right leg was broken in two places, the soft parts lacerated, with violent hæmorrhage. The left leg was also broken, but with only slight hæmorrhage. The cardiac sounds feeble, pulse small, rapid. Amputation of the right leg below the knee. Death on the sixth day from cardiac weakness. The autopsy showed that the right fibula was split high up. There were also three with slight injuries

up. There were also three with singlify described the manifold injuries described the manifold with those of the Russo-Japanese war, we find the reports from injuries from artillery missiles everywhere the same. These wounds are described as most dangerous and frightful. We hear of people who have been so much shattered that only small portions of their bodies have remained; we read of one man who, from the explosion of a shot of large calibre, received not less than 160 wounds, that immediate amputation of limbs was necessary in a large number of troops, and that non-penetrating as well as penetrating ones were almost always complicated by fractures of bones. What horrible devastations are produced by the fire of such weapons is shown by the reports of the wounded of the Warjag, in which, after a fight that lasted half an hour, thirty were killed and seventy wounded. Withal, it is always noticed that shrapnel wounds are almost always infected, as the bullets and fragments of exploded shell almost always carry dirt and particles of clothing with them into the tracks of the wounds. In wounds of this kind the prognosis is therefore very bad. In the bursting of a shrapnel the individual bullets take a course that varies very much, and the rotation of the shell as a whole communicates a centrifugating effect to the bullets with which it is charged. The way in which the balls and exploded fragments fly apart has been likened to the rose of a hose-pipe in which the water is forced outwards from hundreds of openings. But if the rose is also made to rotate rapidly, and when we consider that the bursting charge of every shell adds considerably to the velocity, we shall get an idea of the indeterminate direction taken by the individual parts and of the gravity of the wounds caused by them. Very severe injuries were caused here as well as there by the gases and flames of the exploded shells, the flames reaching mast-high. Similar intense burnings of the skin were reported, for example, from the fight at the mouth of the Jalu, where of the 289 killed and wounded Japanese, 57 men showed burns that extended over more than a third of the whole surface of the body. There were also cutaneous injuries from the burning gas from the powder, principally in the case of shells that, like the shrapnels, were still charged with black powder. They were caused by the hot granules of powder penetrating the skin like fine shot.

#### CLINICAL RECORDS.

#### SARCOMA OF THE MESO-SALPINX.

By F. J. McCANN, M.D., F.R.C.S.ENG., Physician, Samaritan Free Hospital, etc.

THE sarcomatous tumour was removed by Dr. Frederick McCann in May, 1908. The patient, a widow, æt. 52, was extremely feeble and emaciated. Her menstrual periods had ceased for two years, but in October, 1907, she commenced to lose blood from the vagina, which alternated with a yellow-green discharge. Latterly she complained of abdominal pain, swelling and sickness. She was steadily losing flesh and rapidly becoming more anæmic. She had had three children, the youngest being aged 26 years, and for 20 years she had been a widow.

(a) Notes of a case read at a meeting of the Gynmoological and Obstetrical Section of the Royal Society of Medicine, Feb. 11, 1909.

Her abdomen was distended and tender on palpation, but a distinct elastic tense tumour reaching to the level of the umbilicus could be detected rising out of the pelvis. The uterus, which was not enlarged, was situated in front and to the left of the pelvic portion of the tumour. Malignant ovarian disease was diagnosed and operation recommended. The tumour when exposed was found to be of a deep livid colour with omentum and intestine adhering to it, whilst the peritoneum was thickened and ædematous. The adhesions were separated and ligatured, and a quantity of blood clot was removed from the abdomen. The pedicle, which was narrow, was secured by separate ligature of the vessels and subsequent covering with peritoneum. The body of the uterus was not enlarged, and the appendages on the left side also appeared to be healthy. The operation was done rapidly on account of the feeble condition of the patient, but her further improvement was most marked. The wound healed well, and all the stitches were removed. Her friends were amazed at her rapid progress. This, however, was short-lived, for on June 14th, sixteen days later, a change for the worse occurred.

The abdomen was distended, especially on the left side, and impaired resonance was elicited in the left flank. She was very anæmic and extremely feeble. The radial pulse was rapid and badly filled. The abdomen was accordingly re-opened, and the peritoneum found to be still more thickened and gelatinous, several veins requiring to be ligatured in the abdominal wall. There were most extensive intestinal adhesions, which entirely prevented access to the swelling on the left side of the abdomen, which appeared to be composed of matted intestine. Some dark sanious fluid was evacuated from the peritoneal cavity.

As complete removal of the disease was impossible, the abdomen was at once closed. After this operation her feebleness gradually increased and she died five days later.

Permission could not be obtained to have a postmortem examination, and thus the opportunity of verifying what really had occurred was lost.

The tumour when removed measured 7 in. by 4½ in. at the widest end, and 2½ in. in thickness. It was of an irregular ovoid shape, and consisted of two distinct portions. The outer or ampullary half was soft and contained blood clot, whilst the inner or uterine half was firm. This portion was deeply stained with blood pigment, fibrous in appearance, with paler areas scattered through it. The lumen of the tube could be traced running across the mass. Microscopically the growth was found to consist of rounded and oat-shaped nucleated cells, invading the muscular wall of the tube. The blood vessels were represented by channels in the midst of the tumour tissue. There were no epithelial elements and no giant cells. The amount of blood pigment was a conspicuous feature in the sections.

If the nature of the growth had been known at the first operation the proper treatment would have been to remove the uterus, tubes, ovaries and broad ligaments in one piece.

The uterus, although not enlarged, might have contained new growth in its interior, but, if so, it must have been very small. When the tumour was first examined it was thought to be a primary sarcoma, commencing in the muscular wall of the Fallopian tube. Subsequent investigation, however, showed that the unaltered tube could be traced over one surface of this mass, and that the growth had, apparently, originated in the cellular tissue of the mesosalpinx.

#### **OPERATING THEATRES.**

ST. THOMAS'S HOSPITAL.

PYÆMIA FROM ACUTE BONE DISEASE DUE TO
INFECTION WITH THE STAFHYLOCOCCUS AUREUS.—
RECOVERY.—In showing this case, done eight years
ago, Mr. Corner said: This healthy young man, a

plumber by trade, was then æt. 17, and was taken ill with sickness,, headache, chills, and pain in the left leg in 1902. His medical attendant found his temperature during the first fourteen days to vary between 104.8° and 101.8°. On admission, the patient was obviously very ill; he complained of little pain, and his tongue was fairly clean considering the length of his illness. His temperature was 101.6°. He had swellings in the neighbourhood of many joints, with a soft systolic murmur at the apex of heart, which had led to a diagnosis of rheumatism. A follicular rash was present over the chest and abdomen. An anæsthetic was given, and incisions were made into two large subperiosteal abscesses on the internal surface of the left tibia and one of the right tibia, a large abscess over the lower end of the left fibula, another over the left olecranon, the left elbow-joint, the right knee-joint, the left sterno-clavicular joint, and the right sterno-maxillary joint. All the joints contained pus, and at the bottom of the abscesses bare bone was exposed. The lower part of the left fibula was divided and twisted off its lower epiphysis. The bov was very ill and the incisions were made hurriedly. When he was bandaged up fluid was found in the left knee-joint into which a trocar and cannula were left knee-joint into which a trocar and cannula were plunged. The fluid which was withdrawn gave a pure and copious culture of the staphylococcus pyogenes aureus. On the day after operation his temperature rose to 103.8°, the pulse being 116 and the respirations 32. On the next day his temperature was 100.6°, pulse 105. He was eating well and feeling better. All the wounds were discharging well. He was not so well on the following day, and on the fourth day his temperature had risen to 102.4°, later fourth day his temperature had risen to 102.40, later reaching 104.4°; pulse, 130. A large abscess was opened in the right buttock. From the 6th to the 28th day he improved slowly. His temperature varied from 101° to 104.8°, making daily excursions of 3-4 degrees. But his appetite was good, he had no diarrhœa, and the wounds were cleaning. pulse varied from 100 to 148, and his respirations from 24-38. He was treated and the wounds dressed on ordinary lines. No special treatment or serum was given. On the 32nd day his temperature had been slowly descending by lysis, accompanied by diarrhæa, two to six copious and offensive stools being passed daily. An atempt was made by the house-surgeon to remove the sequestrum from the upper part of the fibula. He failed to do this and sewed the wound up. Strange as it may appear, the operation was done on a very septic man in septic surroundings, but the wound healed by first inten-Superficial sequestra came away from the surface of the tibia and other situations. At a later date the fibular sequestrum was removed and the wound sewn up, which again healed by first intention. Throughout a whole month his temperature never came below 100°, ranging from thence to 102°. The diarrhæa noted to have commenced with the decline of the temperature continued throughout the month, 2-6 stools being passed daily. An enema was given during this period with the view of relieving his discomfort. The temperature immediately rose to 103.8°, the pulse to 140, and the diarrhea increased for the next twenty-four hours. The diarrhea was treated by drugs given by mouth, which produced little or no effect upon it. During the following little or no effect upon it. During the following month the temperature still further declined, ranging from 99°—100°, and thence slowly becoming normal.

The diarrhœa declined with the temperature. On the 96th day of residence in hospital the patient was able to walk, and was discharged to a convalescent home.

Mr. Corner wished particularly to direct attention to the following points:—(1) The boy, having been poisoned for 16 days before admission by the staphylococcus pyogenes aureus, recovered. Presumably, therefore, the infection was not the most virulent. (2) Nothing more than ordinary surgical and medical treatment was adopted. (3) The joint, which was only aspirated, and from which the staphylococcus was obtained, never filled with fluid again. (4) On two occasions operations were done on a septic boy in septic surroundings, and the wounds united without a

trace of inflammatory reaction. Presumably the boy, having recovered from the infection, had manufactured his own anti-toxin, and hence it would have been very difficult to make any wound in him sup-purate. The behaviour of the wounds agreed with that of the knee-joint which was aspirated. (5) The diarrheea was obviously the result of a septic enteritis. and prolonged his convalescence. (6) Enemata raised a "storm" when used to relieve the diarrhea, for which drugs and diet were the far better treatment.

FEB. 24, 1909.

PERIGASTRIC ABSCESS, Pyloric OBSTRUCTION, URGENT GASTRO-ENTEROSTOMY.-MR. CORNER operated on a man, æt. 32, with a history of symptoms of gastric ulcer for six months. The patient had been worse for a fortnight, with epigastric pain. On admission he was a thin man, with a swelling in epigastrium, and rigidity of belly wall over it. There was transmitted pulsation and tenderness, with a sense of indefinite fluctuation. The temperature for four days after admission was about 99° to 101° on day of operation, gradually rising. An incision was made through the left rectus above the umbilicus. The general peritoneal cavity was not opened. An abscess was struck at once, which contained about a couple of drachms of thick, white, odourless pus. Film and one ærobic and one anærobic culture from the pus. A drainage tube was inserted. The man improved since this operation, but developed a gastric fistula. After a time the improvement became stationary, and it was increasingly evident that the contraction of the scar tissue of the walls of the abscess were producing pyloric obstruction. It was therefore necessary to do something to relieve the man, with which object he was again brought to the theatre. After the anæsthetic was administered and the abdominal wall cleansed, an incision was made through the upper part of the left rectus to the left of the scar of the former operation. When the peritoneum was opened, it was found impossible to do more than bring a small portion of the stomach to the surface. Owing to the short duration of the obstruction, the stomach was little dilated, and the adhesions of the perigastric abscess prevented its being brought out of the wound. It was necessary, in consequence, to do an anterior gastro-enterostomy. A posterior gastro-enterostomy, Mr. Corner pointed out, was a far better operation in these gastric ulcer cases, and the operation for choice. In this case there was no choice, and an anterior gastro-enterostomy was done by suture. The operation was difficult and tedious. The abdominal wound was closed in layers without drainage.

Mr. Corner remarked that it was very unusual to do an urgent gastro-enterostomy. Such cases could usually wait. But in the present instance there was the un-usual combination of severe stenosis, whilst the stomach had not had time to become dilated. In consequence the man was unable even to take water by mouth. The intake of water is extremely important in these cases, which at times die from lack of water. The most marked instance of the kind Mr. Corner had ever seen was a girl of 20, who had incessant sickness a week after an operation for appendix abscess. Examination of her abdomen did not confirm a diagnosis of intestinal obstruction, or of peritonitis. If this was or mestinal obstruction, or of peritonitis. If this was true "lack of water" might be causing the trouble. The temperature was 96.5°, and the pulse uncountable. Her hands were cold and clammy. Half-a-pint of warm saline was given per rectum. At the end of halfan-hour the girl was no worse, so another half-pint was given, and half-an-hour later the girl seemed a little better. The treatment was pursued, and she had a pint given hourly for ten hours. The result was that she rose from the grave, though her friends, relations, and doctor had regarded her death as inevitable.

Now in this man's case rectal feeding might have been resorted to, but he could not retain the feeds. In consequence, the gastro-enterostomy had to be done without delay. And, as pointed out, this was a difficult operation.

#### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

MEETING HELD FEBRUARY 11TH, 1909.

The President, Dr. HERBERT SPENCER, in the Chair. DR. F. J. McCann read a short communication on SARCOMA OF THE MESO-SALPINX,

which will be found on page 189 of our present issue. Dr. HENRY RUSSELL ANDREWS read a short communication on some cases of ovarian cysts associated with vesicular mole. He gave an account of four cases that had been under his own care:-(1) A case in which a lutein cyst tumour with twisted pedicle was removed after the passage of a vesicular mole. (2) A case in which bilateral lutein cyst tumours, one with a twisted pedicle, were removed 17 days before the passage of a vesicular mole. (3) A case in which small bilateral ovarian cysts, both suppurating, were removed after the passage of a vesicular mole. (4) A case in which a small ovarian tumour was found, while a mole was being removed from the uterus. This tumour became smaller gradually, and the ovary eventually returned to its normal size. He suggested that small ovarian tumours found in association with vesicular mole should not be removed unless they showed signs of twisting of the pedicle or suppuration. He quoted two other recorded cases in which ovarian tumours found at the time of expulsion of vesicular moles were noticed to become smaller and smaller, until eventually no enlargement of the ovaries could be made out. gave a brief resume of some of the recent work on the functions of the corpus luteum.

Dr. G. F. BLACKER read a paper on a case of HYDATIDIFORM MOLE WITH ALBUMINURIA AND THE KIDNEY OF PREGNANCY — SUDDEN DEATH FROM CARDIAC FAILURE.

The patient, a woman, æt. 33, was admitted into University College Hospital on July 18th, 1908. On admission the patient was about 19 weeks pregnant, and for a few weeks had noticed some swelling of the eyelids and ankles, and some hæmorrhage had occurred from the uterus. The urine contained 50 per cent. of albumin, with hyaline and granular casts. She was placed on a strict milk diet, and the albumin became much less abundant. She was found, however, to have well-marked signs of albuminutic retinitis. August 17th and 19th there were severe hæmorrhages from the uterus, and the vision was deteriorating. was therefore decided to induce labour. Bougies were introduced on August 21st, and the cervix began to open up, but early on the morning of the 22nd the woman suddenly became collapsed, fainted, and died in a few minutes. A post-mortem examination showed that the liver was somewhat enlarged, and showed cloudy and fatty changes in its cells. The kidneys were also a little enlarged, and the cortex a little paler than normal. The uterus reached nearly to the ensiform cartilage. Microscopic examination of the kidneys showed marked cloudy swelling and coagulation, necrosis of the epithelium of the convoluted tubules and glomeruli. The ovaries were occupied by a number of cysts mainly derived from the corpora lutea, and they definitely contained an excess of lutein tissue. If we consider for a moment the changes which occur in the mole and in the ovary in cases of resicular degeneration of the chorion, we cannot but be struck by the marked similarity between them. In the mole we have an excessive proliferation of the epithelium of the villi with the formation of cystic spaces, no doubt due to a serous transudation, while in the ovary we have a marked proliferation of the cells of the corpora lutea with the development of cysts possibly of similar origin. Does not this similarity suggest that the same cause, whatever it may be, is acting in the two cases, and more especially when we remember that an excess of lutein tissue is found to accompany normal pregnancy. I do not think the lippothesis that an excess of lutein tissue plays an important part in the causation of the overgrowth of the epithelium of the villi is by any means proved.

THE LORD MAYOR has consented to open the new pathological block of St. Bartholomew's Hospital on Friday, May 7th, at 3 o'clock.

The PRESIDENT (Dr. Herbert Spencer) said that he had long thought that a great deal too much importance was being given to these so-called lutein cysts. When one remembered the frequency with which cysts of the corpus luteum are met with both in the unimpregnated and the pregnant, and the large number of hydatidiform moles which have been removed in the part without the subsequent development of ovarian tumours, he thought that lutein cysts might, in many cases, at all events, be left alone.

Dr. CUTHBERT LOCKYER said that the points definitely known about these compound lutein cysts were that they were possessed of strikingly characteristic features, both to the naked eye and on microscopic examination; secondly, that they were never found excepting in association with vesicular mole and chorion-epithelioma. The point yet to be decided was: What relationship do these ovarian and ovular changes bear to each other? The time had not arrived when this difficult point could be settled. He referred to the occasional disappearance of lutein

Mr. J. H. TARGETT referred to a case where he had performed a double ovariotomy during pregnancy, and the tumours removed were typical lutein cysts. The patient subsequently miscarried and expelled a macerated fœtus. On careful examination it was found that a small portion of the placenta was mingled with the cysts of a vesicular mole.

Dr. R. H. PARAMORE suggested that the underlying cause of the clinical signs found in Dr. Blacker's case was a mechanical one, and referred to the views of Ahlfeld on the causation of eclampsia.

#### ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF STATE MEDICINE.

MEETING HELD FRIDAY, FEBRUARY 5TH, 1909.

The President, W. R. DAWSON, M.D., in the Chair.

THE PRESIDENT read a paper entitled "The Irish Recommendations of the Royal Commission on the Care and Control of the Feeble-minded," in which he gave a short acount of the chief recommendations. In the discussion which followed—

Mr. Louis Kelly, B.L., said he was astonished that such a revolutionary report was so little known and the extent of its recommendations so little appreciated by those who professed to take an interest in the subject. At a recent meeting of a philanthropic society in Dublin a resolution was proposed asking for a grant, the purpose of which was adequately met by the recommendations before them; and at the meeting at which that resolution was proposed, while other Royal Commissions were referred to, the newspaper report was silent as regards the Commission which they were now discussing. In criticising the recommendations he wished to point out that while past and present inspectors of lunatics were exclusively medical men, there was no provision in the law as it stood that those posts should be compulsorily arrogated to medical men. In England there were legal inspectors who had done good work, and he objected to the ex-clusiveness of the recommendations in that respect. The recommendations also proposed to make manent the present local committees who controlled the asylums in the country. He had no great venera-tion for a scheme by which so much control and authority was vested in men who had absolutely no training or qualification for the duties imposed on them. Such committees had done, and were doing, things which no person who was interested in the well-being of the insane could justify. Their very irresponsibility might be taken as an excuse for acts of which he would give some examples collected at random, and in which violence to patients under circumstances which gave no justification for it, and committed by men who were notorious for assault even outside the asylum, was condoned. The President had indicated another weakness in the scheme in regard to the course to be adopted when money was sought to be obtained for building purposes. He objected to the proposed multiplicity of control which only perpetuated one of the fatal defects of the present lunacy system of administration in which there were nine bodies which had a certain amount of power and He could not, however, conceal from himauthority. self that the Report was a marked advance, and its generosity towards Ireland was one of its outstanding characteristics. In the special grant for the provision of necessary accommodation it went further than it did in respect of England or Wales. He hoped the recommendations of the Report would become more generally known, and to some extent carried out, and that it would not be pigeon-holed, like the recommendations of the Vice-Regal Commission on Poor-law in 1891, and others, which proposed the most salutary changes.

Dr. LEEPER said the subject of the care of the feeble-minded and the degenerates of the country was inseparable from Poor-law reform, and the latter would have to come first. In the workhouses, as at present constituted, all the factors that made for degeneracy in the population were being run by State aid. If they reformed the workhouses they would prevent the propagation of degenerates and control the feeble-minded. The speaker said he was old enough to have given written and verbal evidence before the Committee appointed by the Lord Lieutenant of Ireland, the Lunacy Administration, whose report was issued in the year 1891. The recommendations of this Committee were pigeon-holed and were never given any effect to, because they ignored the legal difficulties of the subject, and nothing had been done since to alter or amend the Irish Lunacy Laws. The chief difficulty would be in controlling the feebleminded, who numbered twice as many as the idiots and imbeciles together, and who were capable of doing much more injury to the race than the latter. would be regrettable if they had to depend for the control of the demented and degenerate on the will and whim of Justices of the Peace, one of whom had refused to commit an obvious lunatic who the next day killed a farmer.

Dr. M'VITTIE said the question of teachers for the feeble-minded was a central point. He was of opinion that there were immense numbers of feeble-minded adults who never should have been so. He was satisfied that there were many children in whom intelli-gence developed late, and that such children, if suitably handled by properly trained teachers, might become useful members of the community. Most of them were ruined in school. Nine out of ten of the teachers under the National Board had nearly all the qualities required to make successful teachers destroyed before they were launched. Their nervous systems were ruined, and their capacity to deal with neurotic or delicate children eradicated. He had examined many such teachers. They were excitable and neurotic, and had been worn and worried by studying a great deal of rubbish for examinations. They would be getting something done if they pressed on the Government the importance of selecting teachers with greater care as regards their physical training. propagation of degenerates extended beyond the workhouses. There were children in large towns who were reared in unfortunate circumstances as regards health, and if they were to be sent to schools with long hours he was afraid they must have an ever-increasing ratio

of feeble-minded people.

Miss Buchanan, P.L.G., said she felt deeply the necessity for Poor-law reform, and at the same time trusted that the recommendations of the Commission would meet with attention. The Vice-Regal Report, if carried out, would do much to reform the present shocking state of the workhouses in Ireland, and the with the feeble-minded. The Poor-law dealt with destitution, but the feeble-minded and defective need not be destitute in order to be a source of injury to the community. The public did not know that there was only the Stewart Institution to which an imbecile child could be sent, and there were cases constantly coming before her Board of Guardians in which people not absolutely destitute begged that an imbecile

child should be sent to the Institution. But because the Stewart Institution had come to be regarded by Catholics as an unsuitable place for their children, such children could not be sent anywhere but to the wards of a workhouse. Even a child sent to an English institution had been brought back because it was found that she was of Catholic parentage. There was no place for sane epileptics except the workhouses. The whole subject called loudly for legisla-The recommendations of Royal Commissions were important, but they were no use if they were pigeon-holed.

Dr. Colles said the legal difficulty was illustrated in the recommendation, that the statutory committee of a council, if it did not like the guardianship of a child, could constitute itself the guardian of the child. That had struck the Commissioners as strong, and they provided an appeal to a Court of Summary Juris-diction, and if anyone was dissatisfied with that they could go to the Judge of Assize. He suggested to the Commission that a better plan would be to vest in the County Court Judge the power of appointing a guardian, not only of a child, but of a feeble-minded adult, and power to define the powers which the guardian should exercise over his ward. The Commissioners seemed to be inspired by the idea that if they could get a designation that would not but they could get a designation that would not hurt people's feelings, opposition would be disarmed, but he thought the associations of the term "mentally defective" would ultimately become as objectionable as the terms "lunatic" and "insanity," which were not originally opprobrious.

The President said he was of opinion that the ideal method of dealing with the feeble-minded and every other class of mentally defective, would be to make the whole thing a national service like the Army Medical Service. He thought, however, that it would now be impossible to get rid of the control of the County Councils, and that the recommendations provided for their proper subordination to the central authority had the power to stop the grant if every-thing was not satisfactorily carried out. The number of defectives in workhouses was very large, and the treatment of their mental condition was about as bad as it could be. Many inmates of prisons were drawn from the feeble-minded; almost always they became alcoholic when thrown into criminal associations, and speedily went from bad to worse. The average of previous convictions for Dublin defectives-who constituted 11 per cent. of the inmates of the prisons—was nearly 18. Such facts showed the necessity for interference, and one of the advantages to be derived from any far-reaching system of control would be the placing under detention of women during the child-bearing period, which would diminish, and probably extinguish the supply of defectives.

#### HARVEIAN SOCIETY OF LONDON.

CLINICAL EVENING HELD AT ST. MARY'S HOSPITAL ON JANUARY 28TH, 1909.

DR. WILLIAM HILL demonstrated direct vision laryngoscopy, and tracheo-bronchoscopy. Using Brüning's or Chevalier Jackson's instruments, he showed (1) Growth on right vocal cord; (2) pachydermia of cords; (3) tuberculous growths; (4) tuberculous laryngitis, where the ulcerations had healed under daily direct vision treatment in hospital; (5) subacute laryngitis; (6) chronic laryngitis. He also demonstrated the bifurcation of the trachea. After cocainisation of the larynx, a tracheoscope was passed through the vocal cords during inspiration to a distance of 3 inches. After further cocainisation, Bruning's extension bronchoscopic tube was passed through the tracheal tube to the bifurcation. No coughing occurred in any of these cases, showing the efficiency of Mr. Harrison's method of cocainisation. Dr. Hill also showed the instruments used in œsophagoscopy, and related a case in which he had used it. He showed Chevalier Tackson's gastroscope, together with the laryngeal and tracheal instruments of Kirstein and Killian, which led up to the perfected instruments of Brüning and Jackson.

Mr. Cecil Graham exhibited by direct laryngo-scopy, the condition of a tuberculous patient from whom an interarytenoid tuberculoma had been removed unde chloroform by the aid of Brüning's laryngoscope.

Mr. FITZMAURICE-KELLY showed a case of endothelioma of the tonsil with enlargement of the cervi-cal glands; and also a case of osteo-arthritis of the left metatarso-phalangeal joint of the great toe, asso-

ciated with cystitis.

Dr. Willcox showed a case of collapsed lung with secondary fibrosis in a child. He discussed the possibility of congenital bronchiectasis and fibrosis fol-

lowing phthisis.

Mr. LAMING EVANS showed a case of congenital dislocation of the left hip of the supracotyloid variety in a girl, æt. 7. There was a complete absence of lordosis. Trendelenburg's sign was present.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD IN THE FACULTY HALL, FRIDAY, FEBRUARY 19TH, 1909.

Dr. ROBERT JARDINE in the Chair.

BEFORE proceeding with the business of the meeting, Dr. JARDINE made references to two former Presidents of the Society, namely, Dr. John Lindsay Steven and Dr. Henry Edward Clark, who had recently been

Dr. Henry Edward Clark, who had recently been removed by death.

The Society met for the purpose of holding a "Discussion on the Treatment of Suppurative Appendicitis," which was introduced by communications by Sir George T. Beatson, K.C.B., Dr. T. Kennedy Dalziel, and Dr. Donald McPhail.

Sir George T. Beatson said the discussion was

suggested to him by a case he had under his care in hospital. The patient, suffering from supputation appendicitis, was sent to hospital by a general practitioner. He returned home in three weeks quite well, without having undergone any surgical operation. The practitioner then wrote a letter to the house surgeon calling in question the treatment adopted, and making it evident that he thought it inadequate, if not quite wrong. This made it appear that the prevalent opinion in the profession was that when appendicitis assumed the suppurative form or reached the suppurative stage, it should no longer be treated otherwise than by immediate operation. Dr. Beatson not only thought differently, but his conviction was so strong that he based his practice upon it; and, in comparing results, he found the statistics justified him in doing so. The mortality in cases of suppurative appendicitis was high, and the chief reason for this was the supervention of general septic peritonitis as the result of operation when there was only a local collection of virulent pus in the region of the appendix. He maintained that the proper treatment in localised aprendicular abscess was expectant, and gave his reasons for treating the case medically but carefully for two or three weeks. The most important was that in that time the virulence of the pus and its micro-organisms has greatly diminished, and that if operation was then thought advisable, the risk of general infection of the peritoneum was very slight. Again, the appendicular abscess often ruptured into the bowel, or came to the surface and opened externally, while the adhesions prevented the pus getting into the peritoneal cavity. Waiting also allowed the process of leucocytosis to go on and inhibit the action of the micro-organisms, and prevent their spreading.

In cases where the suppuration was diffuse, early operation was called for, so that Dr. Beatson made a clear distinction between the two varieties of suppurative appendicitis, namely, the localised and the diffused. He also gave reasons for limiting the discussion to suppurative appendicitis. He then gave an illustrative case of: (1) Localised suppurative appendicitis, with its symptoms and treatment; (2) Diffuse suppurative appendicitis, with its symptoms and treatment. Then he pointed out that general peritonitis was not necessarily suppurative, and that the intensity of symptoms was no guide to the severity of local con-

The value of various diagnostic signs was ditions. explained. The treatment of each variety of suppurative appendicitis was then mentioned. Success in early operations for non-suppurative appendicitis was no reason for early operation in the suppurative variety. Even perforation and gangrene of the appendix do not of themselves justify operation; for, in his opinion, the danger of the condition becoming general as the result of operation was so great that he attributed the high mortality of suppurative appendicitis to early operative interference. The principle of opening and getting rid of any collection of pus as soon as possible was good; but in these cases he held that the practice of it was beset with greater danger than that which resulted by leaving the pus to Nature and judicious medical treatment, except in the case of diffuse suppuration, which is a very rare condition. In the localised variety pus is a bar to operation, and operation makes an anxious condition serious. Dr. Beatson prefers to keep the patient on low diet, such as albumen, water, relieve pain with opium, avoid all laxatives, but keep the intestines at rest. Enemata for constipation; boracic poultice locally. Wait till abscess points at surface, which it generally does, or escapes into the rectum, and until the pus is less virulent; then, if you think operation advisable, you can do it with greater

safety to the patient.
Dr. T. KENNEDY DALZIEL began his communication by discussing the ætiology of suppurative appendicitis. He found suppurative appendicitis frequent in certain families, and seeking for an explanation of this led him to examine many appendices other than those removed for disease. He is of opinion that, apart from typhoid fever, dysentery and cancer, a common cause of appendicitis is a stricture at the orifice of the appendix. This is a fairly common condition, and makes the appendix funnel-shaped with the orifice as the narrowest part. This prevents the escape of mucus or foreign bodies of any kind, which act as a source of irritation. A catarrh of the mucous membrane results, which makes the condition worse. This, however, is not a serious condition, unless it goes on to ulceration of the wall of the appendix and empyæma of the appendix. The danger of the localised suppurative appendicitis resulting varies with the micro-organism that is present. When it is only bacterium coli commune that is present the danger is least, it is greater when the staphylococcus danger is least, it is greater when the staphylococcus is the micro-organism, and greatest of all when it is due to streptococci. The pus was first of all inside the appendix, which was blocked with some foreign body, and had its lumen constricted; but many complications might follow upon this: as localised abscesses, adhesions, perforation and escape of pus into peritoneal cavity colon, cæcum, rectum, bladder, ureter and other organs; also thrombophlebitis of the mesenteric veins, and septicæmia without peritonitis. Sympathetic glands in the mesentery may also become infected, suppurate and in the burst, and when this occurs fatal peritonitis is the usual result. With all these complications ready to occur at any moment, Dr. Dalziel thinks the dangers of delay in evacuating the pus are very much greater than any danger resulting from skilful operative interference. He is of opinion that the best treatment of localised suppurative appendicitis is early operation, unless in cases where the operation will lead to general peritonitis. His experience is that the localised abscess may become a general suppurative peritonitis at any time, and early operation is the best means we have of avoiding this, and the other dangerous complications mentioned. The technique of the complications mentioned. The technique of the operation is the important thing, for by defending the peritoneal cavity by gauze from the area of infection it is seldom you cannot prevent general peri-toneal infection. The septic focus can be removed, and you avoid all other complications; whereas by waiting for adhesions to form, you leave something behind which may cause fresh attacks at any time. If there is no general peritonitis, Dr. Dalziel is of opinion that there is no reason for leaving a local collection of pus or a suppurating appendix, and he thinks the proper treatment is to remove it at once.
Dr. Donald McPhail's communication dealt with

peritonitis from the general practitioner's point of view. The commonest form of appendicitis was non-suppurative, and this was not a dangerous condition; his experience being that they did not prove fatal. He then dwelt upon the necessity for careful diag-nosis before deciding upon surgical interference, for if there was no suppuration there was no need for operation. If, however, it could be ascertained that pus was present, he thought it was the best treatment to get rid of it at once. Regarding the use of opium, he considered it cruelty to withhold it for pain. His practice was to give morphia along with small doses-of sulphate of magnesium, as this helped the mucous membrane of the bowel to secrete its juices and so prevent constipation and the formation of scybala. When operation was required at all, it should be thorough, and the drainage of abscess cavities should be down hill through large tubes to be really effective.

Mr. A. E. MAYLARD expressed the opinion that one's hospital experience biased their view regarding conclusions about the gravity of suppurative appendicitis, as only the worst cases were sent there. mortality among them was consequently high. He gave statistics of cases treated in the Victoria Infirmary in illustration of his opinions. He was convinced that a case of appendicitis becomes severewhen pus forms, and that the risks run while it is. present are so great that a radical operation is certainly to be preferred to waiting. There was certainly danger in operation where the pus was localised and there was no general peritonitis; but with care and with the dangers that attended the presence of pus-

in the appendix.

Dr. JAMES C. RENTON remarked that without doubt the virulence of the pus in suppurative appendicitis: was dependent on the kind of micro-organism present in it; yet they could not tell what the nature of the micro-organism was until they had examined the pusfor it. He therefore considered that the sooner a local collection of pus was opened the better. That was the important thing in all cases. Then the appendix could be removed during the same opera-tion, or in many cases he would wait for a week or a few days before taking the diseased appendix away. His experience of general peritonitis from perforation was most severe when due to streptococci, and least so when the bacterium coli commune was the cause.

Dr. JAMES H. PRINGLE expressed the opinion that pus should be evacuated at once, and would make no exception to this rule. He could see no harm in removing the appendix early, nor any advantage in leaving it to be dealt with at another operation. Hementioned the importance of early operation in diminishing the duration of the illness; and considered that for this reason pus should be removed at the earliest possible time. This gave the patient the advantage of a shorter period of acute illness and earlier convalescence. His experience was that apppendicular abscess frequently ruptured into the peritoneum or bowel if not operated upon in time. In the treatment he avoided the use of opium.

Dr. DAVID N. KNOX was of opinion that the expectant treatment in suppurative appendicitis was not good surgery. He adhered to the view that early operation was the best treatment, and he always gave opium

for pain.

In reply to a few questions, Dr. DONALD MCPHAIL stated that no hard-and-fast rules could be laid down to be followed in every case, but that the principle of removing pus when present was certainly to be acted upon when possible.

Dr. T. KENNEDY DALZIEL thought the consensus of opinion was in favour of the views expressed by him regarding the removal of pus as soon as possible. Regarding opium, he would give it for the relief of pain, but not in quantities sufficient to narcotise the patient.

Sir George T. Beatson brought the discussion to a close by re-stating his opinion that early operation was the greatest risk a patient with suppurative appendicitis could run, that there should be no surgical interference till the condition had quieted down, and the

virulence of the pus diminished, which it usually did in two or three weeks' time.

#### LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD ON THURSDAY, FEBRUARY 11TH, 1909.

The President, Mr. T. H. BICKERTON, in the Chair.

Dr. W. B. Warrington described a case of myasthenia gravis in a woman, æt. 32. The ptosis often so readily seen, was not marked, though it could be produced to some extent by fatigue. There was extreme weakness of the masseters, which gave the characteristics. racteristic myasthenic electric reactions. ways the case was quite typical. In other

Dr. GLYNN referred to a case which commenced with giddiness, double vision, and ptosis, the latter being transitory. There was considerable loss of voluntary muscular power of the legs after exercise or excitement, and death occurred in twelve months from bulbar symptoms, these develop-

ing and proving fatal in four days.

Drs. Murray Bligh and Ernest Glynn read a note on the diagnosis of typhoid fever by bacteriological examination. Their method was based on lines suggested by Coleman and Buxton, of New York, particularly in the employment of sterilised ox bile medium. In eight out of fifteen cases of typhoid examined in the second and third week they obtained positive results. The method proved of distinct value in two cases in which the nature of the disease was obscure.

Mr. MONSARRAT read a paper on cancer of the breast. He discussed the difficulties of early diagnosis. He described the extent of the operation undertaken in 37 cases, and their after histories. There was no recurrence in twenty cases during a period extending from five years to one year. Recurrence had taken place in fourteen cases during periods ranging from

four years to within one year.

Mr. PAUL referred to the importance of removing breasts affected with intractable involution mastitis before they become malignant, and the great value of rapid sections. He thought the modern operation gave decidedly improved results. Mortality from the operation was very low. He had removed the breast over 200 times during the last five years without a death, and had no death since year. In thirty work death, and had no death since 1901. In thirty years he had had only four deaths from breast operations two from sepsis and two from acute mania.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE, Paris, Feb. 21st, 1909,

AEROPHAGIA is a gastric symptom known for a long time, but its semeiology has been only recently studied. It is characterised by abundant and frequent eructations observed in dyspeptic and neurotic persons.

The gas expelled at the time of these eructations,

and with which the stomach is charged, can either be produced by gastric fermentation, as in the case of dyspepsia, or may be derived from air unconsciously swallowed by neurotic persons. It is to this deglutition, followed by more or less abundant eructations, that the name of aerophagia should be reserved.

The gas accumulated in the stomach provokes distension and flatulence, and exercises a certain compression on the neighbouring organs-sensation of oppression, palpitations, irregularity in the cardiac rhythm,

tympanitis, general lassitude.

These phenomena become still more exaggerated at the moment when eructation is about to take place. Patients frequently suffer at this point from vertigo. dizziness, with a tendency to fainting.

But when eructation sets in-which the patient tries to provoke by swallowing a new dose of air, so as to establish the equilibrium between the exterior pressure and that of the gastric gas-a feeling of immediate relief and bien-être supervenes.

The patient frequently ignores the special nature of this tic of gaseous deglutition; the medical attendant whose attention is not drawn to the fact sometimes neglects to examine the nervous condition of the patient, and ascribes to gastric fermentations the eructations from which he suffers.

However, in these cases the digestive functions, although not absolutely perfect, are not troubled to the point of causing such accentuated fermentations.

Anyhow, the anti-putrid treatment—charcoal, gastric

antiseptics, alimentary regime—have no effect on the troubles of the patient. The exact origin is only discovered by attentively examining the patient. Before eructation he fills his mouth with a certain quantity of air, which he sends down to his stomach by hermetically closing his mouth, bending his chin towards his chest, and making a motion of deglutition with a slight noise due to the raising and descent of the pharvnx.

The air expelled is absolutely inodorous, and is thus distinguished from the putrid gases of gastric fermentation.

According to Dr. Lyon, aerophagia sometimes takes the form of a convulsive attack, and the patient feels it coming on like an attack of epilepsy. Preceded by dizziness, noises in the ears, vertigo, general uneasiness, the phenomenon sets in; the patient is obliged to stand, and for a variable length of time emits sonorous eructations in rapid succession, when the attack ceases, leaving him in a state of complete lassitude.

Mental examination of these patients confirms the diagnosis. The majority are, if not hysterical in the true sense, hyper-nervous; they are certain that they are suffering from acute gastritis, grave dyspepsia, cancer of the stomach, etc. They refuse to eat for fear of increasing their suffering, and thus their general condition suffers from insufficient alimenta-

The diagnosis of this affection is not very difficult, as the attention of the medical attendant is drawn by the patient himself to the eructations, and it is for him to discover their origin. The almost negative examination of the stomach--palpation and percussion reveal nothing abnormal, the absence of odour in the gas rendered, the interrogation of the patient as to his nervous and mental condition, should put him rapidly on the track.

The treatment of aerophagia should be addressed to the cause—suppression of deglutition of air. This is difficult, as the patient will refuse to believe that his ailment is of purely nervous origin, and will insist

So as to accord to a certain extent with his ideas, non-alkaline digestive agents will be prescribed, notably ferments, and the patient will be persuaded that he will completely prevent eructation by stimulating the certain function. lating the gastric function.

But at the same time he will be recommended to make no effort at deglutition outside his meals, and to place a piece of cork between his teeth at the end of the repast, for deglutition of air is impossible with the mouth open.

HEMOPTYSIS AND HEMATEMESIS.

It is sometimes impossible, when in presence of a patient who vomits blood, to know at once if the hæmorrhage is of gastric origin or if it comes from the lungs; if it is hæmatemesis or hæmoptysis. If, however, the question is of primary importance in the ulterior treatment of the affection that produced it, it occupies a second place as regards immediate treatment. For the moment the essential point is to arrest the hæmorrhage, says Prof. Huchard, regardless of its origin, and this is generally obtained by temporary suppression of food, rest, complete silence, one or two injections of morphia, and, in the case of hæmophilia, injections of anti-

diphtheritic serum.

The days following the initial cause becomes more or less apparent through information obtained from the family of the patient and a careful examination, eliminating lesions of the nose, mouth and pharynx.

According to the information received and personal observation, different affections might be incriminated.
Ulcer of the stomach, if the patient suffered from industrian sensation of burning, and acute pain in

the epigastrium.

Hepatic affection (cirrhosis or tumour) producing small varicose veins in the esophagus or of the stomach, if the complexion wore an interic tint.

Pulmonary tuberculosis, if the vomiting of blood has been preceded by wasting, cough, night sweats. Mitral disease, if the congestive lesions observed in the lungs yield to the administration of dilatation. Infarctus, if a bruit de valor is heard in the heart on Infarctus, if a bruit de galop is heard in the heart on the patient walking rapidly for a few moments.

Cancer of the stomach is revealed by the cachectic

condition of the patient.

Aneurysm of the aorta is difficult to recognise, and

frequently radiography has to be resorted to.

Hæmorrhage has been observed in certain general maladies, as grave icterus, scurvy, leukæmia, infectious endocarditis, auto-intoxication of renal origin, and such local lesions as ulcers of the duodenum, alcoholic gastritis, hydatid cysts of the lung, pulmonary syphilis or poisoning by injection of caustic substances substances.

The exciting cause of hæmorrhage discovered and the question of hæmoptysis or hæmatemesis settled; the way is opened for the treatment.

In hæmoptysis the suppression of food need not generally exceed 24 hours; in hæmatemesis it should be prolonged three or four days and even longer, the patient being nourished by enemas. In hæmoptysis where hypertension generally exists, hypotensors as inhalation of nitrite of amyl, trinitrin, mistletoe give encouraging results. Ergotin, chloride of calcium,

or both alternately, may be tried.

Hæmatemesis should be treated by subnitrate of bismuth and bicarbonate of soda. Surgery comes in only where the hæmorrhage persists in spite of all

other treatment.

The resulting anæmia should be treated with physiological iron as afforded by hæmoglobin, which is easily assimilated and produces no accidents.

#### GERMANY.

Berlin, Feb. 215t, 1909.

At the Verein für Innere Medizin, Hr. Strubel spoke on

VACCINE TREATMENT. He said that, with regard to all therapeutical measures, it was necessary that they could be easily carried out by the practitioner. It was not a simple procedure that had been given to the world by Almroth E. Wright—the determination of the opsonic index and the vaccine treatment depending on it-but a very complicated method. In London as well they had not been able to determine the index as often as could be desired, and a modified method had been made use of. speaker had attempted to simplify the process; he had determined the index for some length of time in cases of tuberculosis, and had then applied the vaccine treatment without again having recourse to a fresh index, and with very good results. The like took place with regard to staphylococcus diseases; they also were successfully treated by vaccine without determination of the index. He had now had the vaccines prepared in the factory, and had made use of them in 40 cases successfully, and without setting up any reaction. In cases of chronic acne a longer time was, of course, necessary (several months) to bring about the result that was desired. The vaccines had been prepared in the was desired. Ine vaccines had been prepared in the Güstrow chemical works, and they would shortly be on the market under the name of "opsonogen"; I commontained no millions of staphylococci. An ordinary furuncle had already been cured by two injections. In order to prevent relapses a lengthened series of injections should be made twice a week. From the speaker's own experience he should say that there was not the slightest objection in placing "opsonogen" in the hands of the general practitioner. Wright had also recommended a similar procedure in the Practitioner.

Hr. Rosenheim next related a case of Wright had also

ACTINOMYCOSIS IN CARCINOMA OF SIGMOID FLEXURE. A gentleman, æt. 61, who had always been otherwise

healthy, complained that for a year he had suffered from constipation, but that latterly he had had attacks of abdominal pain with vomiting and diarrhæa, which, however, always passed off quickly of themselves. In nowever, always passed off quickly of themselves. In the autumn of last year he experienced a feeling of pressure over the bladder, and pain in the left inguinal region. Nothing special could be felt on palpating the abdomen. A later examination, however, showed a considerable collection of fæces in the neighbourhood of the sigmoid flexure. An endoscopic examination showed a growth that blad engilly covered with macous showed a growth that bled easily, covered with mucous membrane, in which were large vessels. An examina-tion made a few weeks later revealed the following: The tumour was unchanged on the left, but on the right there was a deposit some centimetres square, greyish-brown and slimy, like necrotic tissue. From this carcinoma of the sigmoid flexure was decided on. The masses that appeared to be necrotic proved to be harmless, only slightly changed mucous membrane. In the mucous membrane over the tumour, actinomycoses were found, but no intestinal mycosis was diagnosed during life. The case showed that such fungi could develop anærobically. The troubles were caused by the development of the stricture; the intection caused no symptoms. The mycotic covering had a thickness of 2 mm.

In view of Workmen's Compensation Acts, the relationship of certain diseases to accident becomes one of importance. Two such cases are quoted in the Deutsche Med. Zeit., February 11th, 1909, communi-

cated by Dr. H. Strohe, Köln.

Both the patients were young men who had been healthy up to the time of the accident, and both fell neating up to the time of the accident, and both fell from a considerable height. One complained of pain in the inguinal region, which ceased, but returned with fever on attempting to stand, and which gradually became more and more fixed in the region of the cæcum. An operation was performed six months later. A band was found, like a tight ligature, round the extremity of the vermiform appendix, which was in an almost gangrenous condition. In the other case the patient complained from the first of pains in the inguinal region and back; the first-named pain disappeared, but that in the back remained. The abappeared, but that in the back remained. The ab-dominal pain soon returned, however. Laparotomy was performed three months after the accident. A very long vermiform process was found, the extremity of which was fixed to the lumbar vertebræ. On separating the adhesion the serous covering of the distal end was left behind. During the course of a few weeks an abscess formed at this spot, which pointed towards the

middle line of the abdomen, and was there opened.

In both cases the writer believed there was a causal connection between the accident and the appendix mischief, that in the first case the disease was produced by a contusion of the abdominal wall; in the other case the unusually long processus had become attached to the contused lumbar vertebræ, the contusion being

caused by the fall.

## AUSTRIA. Vionna, Peb. 21st. 1909.

TRACHEAL STENOSIS AND OSTEOPLASIA. Moszkowicz presented a female patient to the members of the Gesellschaft der Aerzie on whom he had successfully operated for stenosis in the trachea.

The patient was 37 years of age, with a defect from infancy that threatened to prove fatal. After much thought and consultation he decided to operate after Schimmelbusch's method to relieve the woman's distress. He found later that he would have to modify the operation, and divided the description into three parts:—(1) The mobilising and distending of the trachea according to Küster; (2) the covering of the various parts with periosteal tissue from the sternum and the clavicle, after Schimmelbusch's method; and (3) the covering of perichondrium in the cartilaginous regions. SYRINGOMYELIA.

Schlesinger presented a woman who had twice been confined, and on both occasions had no pain, or rather did not experience pain, neither could she tell when any movement took place in the abdomen. This peculiar condition depended on the special or specific

as Schlesinger wishes to call it, supply of the sympathetic in the peritoneum, and walls of the uterus being quite lost, or that no communication existed between these and the spinal cord. This specific sensation of the uterus can be quite destroyed without any obvious loss to any other textile position of the abdomen, as the centre of the cord is not the only path for transmitting these sensations, but it is diffused throughout the white substances. It should be noticed that uterine sensations would enter the cord in the sacral region, which render them subject to interruption in passing to the cerebrum. Proof of this specific uterine pain can be demonstrated by dividing or partially dividing the posterior horn of the spinal cord. Latzko remarked that the uterine pains, sensations of the outer surface of the uterus and sensations of the inner surface of the uterus were not conducted by the same path. He admitted, however, that the movement of the child under normal conditions was conveyed by the apparatus that transmitted the internal surface of the uterus, although it was possible, and experiments sometimes tended to prove that the peritoneal surface was also transmitted through the same channel. Schlesinger said that the peritoneum was more frequently free from pain than in any other condition of syringomyelia. He re-corded a case of perforation where severe peritonitis was present, but the patient was quite free from pain to the last.

MYOGENIC CONTRACTION.

Erben exhibited a three-year-old child, who, having recovered from a broken arm, had all the symptoms of myogenic contraction. During the treatment the fingers assumed a claw-like appearance under the bandages. There was no lesion of the nerves, while the phalanges when stretched out contracted firmly, indicating that the conducting power of the nervus radialis was intact. There was no atrophy in the muscles of the hand or in the fingers, which usually occurs in peripheral paralysis. He considered the cause to be one of a fibrous inflammatory retraction, or possibly an ischæmic condition of the muscles. Moskowicz was of opinion that the contraction was due to ischæmia, which was not infrequently the case in fractures of the lower third of the humerus. This lesion was usually attributed to a tearing of the arteria cubitalis, probably producing a hæmatoma that may prevent the easy formation of collateral circulation, and thus affect the whole group of muscles in the forearm by damaging the circulation. It is possible that a necrosis and degeneration of the fibrous tissue may be induced, but it is purely of a myogenic nature, and never under any circumstances akin to a neurogenic contraction.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

#### OXYGEN IN SPORT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—In your issue of February 17th a paragraph appeared on "Oxygen in Sport," in which the experiments of Dr. Leonard Hill on athletes, and his lecture at the London Institution, are commented upon. Dr. Hill, it would appear, has found that 'oxygen has a wonderful effect on athletes." He has shown that a draught of this gas when a boxer was winded had the power of restoring him wonderfully and increasing his staying capacity. The same thing was observed in hockey and football players. This, you say in your annotation. "may be good physiology, but it is bad sport." With regard to the question of sport, that is, of course, a matter of opinion. The subject has, however, been so thoroughly thrashed out of late in the columns of the daily and weekly Press that it is un-necessary to discuss this point further. With refer-ence to the physiology of the inhalation of oxygen in sport, I would call your attention to the fact that the very elementary observations made by Dr. Hill, the conclusions of which, based entirely upon the statements of his subjects, are totally wanting in

physiological control, were anticipated by me seventeen years ago. At that time I contributed an article on the physiological action of cycling to La Semaine Médicale. I made also a series of experiments, which were fully reported at the time, and are well-known to all sportsmen and athletes in France. I devised different forms of apparatus for the administration of oxygen, not only before and after, but during actual effort. I took sphygmographic tracings of the pulse at the moment of extreme loss of wind, which showed the almost total absence of tension in the left heart, resulting from the difficult circulation of blood through the lungs; also after the inhalation of oxygen, which restored wind at once by rendering the lung adequate to the extraordinary demand on it, thus enabling the blood to pass freely into the left ventricle, and so restoring tension. The apparatus I devised was tried by many cyclists, and would doubtless have come into general use but for the objection of sporting authorities.

I forward herewith a copy of a pamphlet in which the subject is more fully discussed, and you will find in it the text of the articles published by me in 1892, with the pulse tracings above alluded to, as well as others of a sporting interest. I do not pretend to have been the first in this field, for it is quite possible that others may have preceded me. My experiments, how-ever, show once more that there is "nil novi sub sole."

I am, Sir, yours truly, ary 19th, 1909. OSCAR JENNINGS. Paris, February 19th, 1909.

THE CENTRAL MIDWIVES BOARD AND SEPSIS. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent in the last week's issue, who styled himself "Pathologist," appeared to be startled at the indifference of the Central Midwives Board to the dangers of puerperal sepsis, and then stated that, contrary to all modern teaching it directs candidates preparing for examination to make during labour "repeated abdominal and vaginal examinations." Now, by reference to the Rules framed by the Board, the writer of this letter will be able to discover that these words occur in the certificate which must be produced to prove that the candidate has undergone the required course of practical training under a registered medical practitioner or a certified midwife appointed by the Board, and that she has also attended and watched the progress of not less than twenty labours, and, under personal direction, that she has had the opportunity of obtaining by internal and external examinations a practical knowledge which can be secured in this way without any risk to the patients.

I hope this explanation will be satisfactory to "Pathologist," and that he will be comforted by the assurance that the Central Midwives Board is quite as anxious as he appears to be to stamp out puerperal sepsis, and to protect the poor women of our country against ignorance and preventable disease.

I am, Sir, yours truly,

JOHN WARD COUSINS.

Portsmouth, February 22nd, 1909.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. Sir,—Heaven forbid that I should undertake the task of offering an apologia for the actions of the Central Midwives Board, because too many of the actions of that body are incapable of defence. I think, however, that in the present instance "Pathologist" is a little too hard upon it. He is quite right in thinking that modern obstetrics teaches the necessity of avoiding vaginal examinations as much as possible; but, at the same time, it recognises that one such examination is necessary in every case, if for no other purpose than to exclude the possibility of the presence of pathological conditions of the vagina. To make this examination with satisfactory reults, the nurse must acquire experience, and how can she do this unless she makes "repeated vaginal examinations" during her training? It is surely far better tions" during her training? It is surely far better that she should make them then, when presumably she is under proper control and supervision, instead of after her traume, irresponsible position.

I am, Sir, yours truly,

OBSTETRICIAN. of after her training, when she is in a comparatively

RUNNING FOR BOYS.

10 the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—It seems to be the fashion nowadays for groups of medical men who happen to hold strong views on any point to publish manifestoes for the instruction of the public. Thus, a year or two ago, we had the "Alcohol" and the "Anti-Alcohol" manifestoes, and now we have Sir Lauder Brunton and his friends declaring ex cathedra against long-distance running for boys. Views expressed in this manner do not usually carry much weight with the profession, but with the public there is a danger that they may be regarded as expressing received medical opinion. As a matter of fact, is there any evidence that, on the whole, running is bad for growing boys? I know of none, but, on the contrary, there is plenty of evidence that the boys and young men who have been distinguished as athletes in school and college life are longlived and healthy. Their lives are, in fact, in insurance phraseology, "first-class." Examination of the lives both of old "Blues" in this country and of men of similar distinction in America has quite contradicted the tradition of high mortality among athletes. It is not, of course, to be denied that running may be of injury to an occasional boy, but, on the whole, long-distance running tends to reject the unfit early, and without much injury to themselves. There is no doubt that it develops certain admirable qualities—perseverance, courage, determination—which the onlooker at a football or cricket match may admire in others but has little chance of cultivating for him-The schoolboy will either look on or take part letics. Those who love manliness prefer to see in athletics. him do the latter.

I am not an ardent admirer of the recent developments of the "Marathon" craze, but, at any rate, experience has shown that the tests, severe as they are, are not followed by any permanent injury to the competitors.

I am, Sir, yours truly,
OLD RUNNER.

#### OBITUARY.

DR. LINDSAY STEVEN.

THE sickle of death has been busy lately among the distinguished medical men of Glasgow. We have now to chronicle the death of Dr. John Lindsay Steven, in his 51st year, which took place at his residence rather suddenly on February 14th, 1900. It was not known that he had an affection of the kidneys for the last two years, and his death seems to have been precipitated by an acute attack of nephritis, complicated with pericardial effusion. Dr. Steven was in the full zenith of his powers, and his services as a reliable consulting physician were much in demand. For nearly thirty years he had worked and prepared himself for high professional distinction, and was about to er joy the full fruits of his strenuous and honest career when he was called to his rest.

Dr. Steven was a graduate of the University of Glasgow, receiving his M.B., C.M., with honours, and winning the Brunton Memorial Prize as the most distinguished graduate of his year. After a sojourn on the Continent, he was appointed pathological assistant to the late Joseph Coats, a name still revered for his work in pathology in Glasgow. Dr. Steven spent many years with Coats, and was of great assistance in helping students in acquiring a sound pathological training. He, early in his career, published a small handbook on practical pathology, which was distinguished for its lucidity, and was a reflex of the Glasgow teaching. About this time he likewise was a clinical assistant to the late Professor McCall Anderson, a man distinguished for his energy and fertility of resource in the therapeutics of disease. When Dr. David Newman retired from the lectureship of pathology at the Glasgow Royal Infirmary, he was succeeded by Lindsay Steven, who proved himself an expert pathologist, and one who could advance the science by his splendid gifts. It is, perhaps, to be regretted that Dr. Steven chose in the later part of his career to pursue clinical medicine and to renounce his purely pathological work, as it must be known,

judging from the character of it, that he would sooner judging from the character of it, that he would sooner or later have attained what was perhaps the great ambition of his life, namely, professorial rank. At the time Coats died, Steven had become a physician to the Royal Infirmary, and had hived off from pathology, so that when Professor Muir got Coats' chair, Steven's chances were handicapped. About three years ago, when James Finlayson died, Steven was unanimously chosen as his successor in the Western Infirmary, an appointment that met with the hearty approval of the medical profession in the West of Scotland. Had he been spared long enough, he of Scotland. Had he been spared long enough, he would, in all probability, have risen to professorial rank in medicine.

Dr. Steven was a man of a calm and reflective type of mind, who took life seriously and earnestly, and was actuated by the highest Christian ideals. He worked steadily and conscientiously, and any success he attained seemed to be the logical result of the work done. He employed no arts to attract practice; he sought no notoriety by any eccentric habits of mind; and he was deeply respected by students and practitioners, for he never seemed desirous to enhance his fame by taking advantage of the mistakes or omissions on the part of the family attendant. He made a thorough examination of the patient, and stated his opinion honestly and as charitably as circumstances permitted.

Dr. Steven's most important contributions to medi-Dr. Steven's most important contributions to medicine are: on the "Suppurative Diseases of the Kidneys"; on "Mediastinal Tumours"—a work of European reputation; on "Fibroid Diseases of the Heart"; on the "Coronary Arteries," and many other subjects. His clinical contributions, while marked by accuracy of observation, were not so profound as his pathalogical contributions.

found as his pathological contributions.

Dr. Steven received during his life time many marks of regard from his professional brethren. He was Honorary Librarian to the Faculty of Physicians and Surgeons, Glasgow; a past-President of the Medico-Chirurgical Society, and also a member of the General Medical Council. In all matters affecting the welfare of his professional brothers have been been sometimed. of his professional brethren he took a leading part, and at medical meetings he was a faithful attender. and what he had to say was to the point and in-structive. Dr. Steven had been married a few years, and much sympathy is felt for his widow in her sudden bereavement.

### EMERITUS PROFESSOR D. J. HAMILTON, M.B.,. LL.D.Ed., F.R.S.

WE regret to have to announce the death of Professor Hamilton, which took place at his residence on February 19th. Professor Hamilton had been in failing health for about a year, and resigned his chair in the University of Aberdeen last autumn, on account of his inability to attend to its duties. Professor Hamilton was a native of Falkirk, and graduated in Edinburgh in 1866. He studied pathology in Vienna, Munich, Strasburg, and Paris, and on his return to Edinburgh was appointed assistant to the late Professor Sanders, then Professor of Pathology, and was also appointed Pathologist to the Royal Infirmary. As a teacher and demonstrator of pathology he was extraordinarily successful. All his old pupils are agreed that his instruction was unsurpassable in its lucidity and in-terest. On account of the state of Professor Sanders' health, a great deal of the work of the chair devolved upon Dr. Hamilton, and when the professorship fell vacant it was a keen disappointment to very many of Hamilton's friends and pupils that he was not selected to succeed Sanders. In 1882, however, he was elected to the chair in Aberdeen, and it is safe to say that no one has ever shed greater lustre on the northernmost of our Universities. Dr. Hamilton's work on pathology is too well-known to require reference. He wrote a deservedly admired text-book on the subject, and made many important researches, among which those on tuberculosis, on the topography of the brain, and on "braxy" in sheep may be mentioned. He was a musician, and an artist of no little merit; the collection of painted casts and models in the museum of Aber-deen University bear testimony to his skill with the

#### THE ROYAL COLLEGE OF SURGEONS IN IRELAND -ANNUAL DINNER.

THE annual dinner of the Royal College of Surgeons in Ireland was held on Saturday, Feb. 20th, and was very largely attended. His Excellency the Lord Lieutenant was present, and a large party of the Viceregal Household. Before dinner there was a pleasing ceremony at which the President of the College presented Professor Alec Fraser, Professor of Anatomy in the College School, with a casket containing a cheque, in token of the manner in which the Council of the College appreciated his services to the school to which he had been attached for 25 years. After dinner the health of Professor Fraser was included amongst the toasts. Dinner was excellently served and at its conclusion and after the King's health had been drunk, the President, in proposing the health of the Lord Lieutenant, said: As they were aware, the Royal College of Surgeons was at present engaged in a struggle for what they considered their rights. (Hear, hear.) They were striving to obtain from the Government their due share of the endowments which were at present being distributed for educational purposes so largely in this country. That was not the moment for airing their grievances, but he would like to lay it down that they did not abate one tittle of their demands—(hear, hear)—and he would like that any words of his that night would be taken—as the lawyers said—without prejudice as regarded their claims. He was convinced his Excellency sympathised with them and was their friend, and would like to assist them in every way he could. (Applause.)

His Excellency, in the course of his reply, said that he would try to adopt the same method as that which had been followed by the President, namely, in clearing the ground in regard to a most important matter, as to which he made a discreet but very clear and definite reference. To have omitted allusion to a subject in which the Royal College of Surgeons naturally feels such a profound interest, would not have imparted a sense of reality to our proceedings; while, at the same time, as the President evidently recognised, it is not exactly the occasion for anything of the nature of a discussion. He would only say that the sentiments of good-will which have just been attributed to himself do exist, and glad indeed would he be if he could say more, but, as they were no doubt aware, the administration of public funds is not one of the matters which are, in any direct manner, allotted to the Lord Lieutenant, his share in such being only of a collateral sort, or perhaps even less than that expression would imply. However, the

subject is, at any rate, still under consideration.

Dr. R. H. Woods, the Vice-President, then proposed the toast of "The Guests," and this toast was responded to by Mr. Justice Kenny, the Provost of Trinity College, and the Rev. T. A. Finlay, S.J. The President next gave the health of Professor

Alexander Fraser, on the occasion of his 25th year of work as Professor of Anatomy in the Royal College of Surgeons. (Applause.) They had seen him (the President) just before the dinner present Professor Fraser with a testimonial in the form of a silver casket containing a cheque, and he told him at the time that this presentation was unprecedented. It was unprecedented in his time, and he had never known the like to have occurred before, but the College of Surgeons thought the occasion was worthy the creation of a precedent. Never had the College been better served than by Professor Fraser. (Applause.) The position of Professor of Anatomy was far and away the most important in any school of surgery or medicine. The study of anatomy was the base on which all knowledge was founded. Professor Fraser had been an exceptional Professor of Anatomy. (Applause.) The presentation was made as a testimony to the incessant and untiring industry of Professor Fraser in the management of the splendid anatomical school which he had always placed at the disposal of every student of the College.

Professor Fraser, in reply, mentioned that there was not one there that night who was a member of the Council when he first made his acquaintance with it, save Sir Charles Cameron. As to the anatomical de-partment of the school, the audience would be some-what astonished to learn that it did not make a bad second to that great institution, Trinity College. (Applause.) The anatomical returns for the past 25 years when counted up were roughly 4,570 for Trinity College, 3,730 for the Royal College of Surgeons, and 3,230 for the Cecilia Street school—a proportion of 15 for Trinity, 12 for the College of Surgeons, and 10 for Cecilia Street. That was not a bad record for the anatomical department of the Royal College of Surgeons, which had always been more or less selfsupporting.

The Lord Lieutenant proposed the last toast, that of "The Royal College of Surgeons." His Excellency said that any words spoken in connection with this toast must necessarily be those of congratulation. The College of Surgeons was an institution that had done magnificent work for the country. (Applause.)
The toast having been duly honoured,

The President, in responding, said he might put the case for the College in two or three words. There were at present in Ireland six medical schools. There was Trinity College, which was richly endowed since the reign of Queen Elizabeth. There was the new National University College, and there were the Queen's Colleges of Cork, Belfast and Galway, and there was the school of the Royal College of Surgeons. Trinity College, as he had said, was well endowed, and the other four Colleges were in receipt of annual grants from the Government, which had been largely increased by the Universities Act. The College of Surgeons, however, did not get any grant. Although it did its work as well as any and better than many of them; but it got no support of any kind whatever. It had to depend absolutely and entirely on the results of its own work and on the fees from the students. That and the fact that medical education had of recent years become a very expensive thing, and therefore could not be carried on as a commercial success were the salient points in their case. It was, he thought, a further recommendation in their favour that their institutions, their schools, and their collegewere non-political and non-sectarian institutions He thought they might believe and hope that the Government would see in time that they should be placed on a level with other schools in Ireland to enable them to carry on their work. Unless some assistance came sooner or later that college must succumb to the State-aided assistance given to other colleges and schools by the Government. They hoped the Government would see their way to grant them equal treatment in this direction. (Hear, hear.)

#### REVIEWS OF BOOKS.

NALL AND LONGRIDGE'S AIDS TO OBSTETRICS. (a)

STUDENTS of medicine and pupil midwives preparing for the "orals" of the ordinary qualifying examinations, and desiring to memorise what they had already learnt from text-books and at lectures on obstetrics, would find the latest edition of "Aids" of very great service.

Longridge, with the experience of a teacher and examiner, has revised the work and brought it well up to date in every respect. He tells the student, in as few words as possible, everything he should know to satisfy an examiner at the orals, from whom, of straightforward questions are expected. No course, straightforward questions are expected. chapter can be said to possess any special merit raising it above another, the same level of excellence being maintained throughout. All the essentials of mid-wifery, and these alone, are dealt with; no space is taken up by debatable points. Students are expected to be familiar with every subject recalled to their minds by this synopsis. The book is well got-up.

(a) "Aids to Obstetrics." By Samuel Nall, B.A., M.R.Cantab. M.R.C.P.Lond. Revised by C. J. Nepsan Longridge, M.D.Vict., F.R.C.S.Eng., M.R.C.P.Lond. Seventh Edition. London: Bailliere. Tiodali and Cox. 1908.

### SUMMARY OF RECENT MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

Observations on Injuries of the Neck of the Femur in Early Life.—Whitman (Med. Record, January 2nd, 1909) states that it is generally assumed that all fractures of the hip in early life are epiphyseal separations. Of 84 cases collected from the literature by Hoffa in 1903, 80 were called epiphyseal fracture, and 4 reported by the author, fracture of the neck. During the first ten years of life at least, epiphyseal separation is unusual because the junction is protected by a firm enclosing covering of cartilage, reinforced by periosteal tissue. In adolescence the junction between head and neck becomes relatively weak. The differential diagnosis between the two conditions is important as regards treatment. Injury to the hip in a healthy person resulting in immediate disability and presenting the physical signs of fracture, whether in childhood or adolescence, is far more likely to be fracture of the neck than at the epiphyseal junction. If, on the other hand, the subject is an adolescent, particularly of the weak, rapidly growing or overweighted type; if the symptoms were induced by comparatively slight injury; if the debility was not complete, but slowly progressive, the probability is that the lesion is an epiphyseal fracture. If the separation is immediate and complete, the injury is usually more severe, and the disability is correspondingly greater. The final results of untreated cases of fracture of the neck are distorsion and apparent shortening of the limb, but comparative freedom of motion in directions not opposed by the deformity, the limitation of motion being especially the loss of the power of abduction due to coxa vara. In epiphyseal displacement there is, in addition, great limitation of motion, or partial ankylosis resulting from disorganization. sation of the joint, with a certain degree of shortening due to loss of growth. In fracture of the neck, if the case is seen early, the limb should, under traction and by carefully applied force, be placed and fixed in complete abduction for the purpose of reducing deformity. If repair has taken place, a sufficient wedge of bone should be removed from the base of the great trochanter to restore the angle of the neck and thus the range of abduction which is dependent on it. In rare cases epiphyseal separation may be complete, so that a disengagement and replacement of the fragments by manipulation may be possible, but usually the fragments are firmly adherent to one another and reposition is impossible without open operation. In these cases the anterior surface of the joint is exposed, and the capsule is opened by a straight incision in the line of the neck. The removal of a thin section of bone from the neck is often necessary to permit the insertion of a chisel with which the fragments must be prised apart to permit replacement by abduction and inward rotation of the shaft. The author outlines 15 cases to illustrate four types of fracture of the neck of the femur in early life as they are likely to be presented for treatment. (1) The unusual cases in which a correct diagnosis permits immediate correction of deformity by manipulation. (2) Cases in which the fracture has consolidated, the deformity being of a coxa vara type, which may be corrected by cuneiform osteotomy of the shaft without disturbing the joint. (3) Ununited fractures which require direct operation for the purpose of fixing the fragments. (4) Epiphyseal fractures, in which the joint must be opened.

Contusion of the Lung without External Injuries.—Payne (Brit. Med. Journ., January 16th, 1909) reports the following case:—A labourer, who up to the time of his accident felt in perfect health, while at work fell over a beam on to his right side. Not feeling very seriously hurt at the time, he continued work for two

hours and then went home. By this time the pain in his side was so bad that he went straight to bed. There he remained, and gradually got worse. On the author being called in to see him the third day after the accident, the patient was found to have marked dyspnœa. There was no sign of external injury to the chest, except redness and tenderness on pressure over a region towards the base of the right lung, where the patient complained of internal pain. There was marked dulness on percussion in this region. The general impression was a man in the second stage of pneumonia; the immediate danger was cardiac failure. The patient died a few hours later, exactly 71 hours after the accident. At the autopsy, there were found no signs of injury to the thoracic wall, no ribs were fractured, there was no laceration of the soft tissues. Extending inwards, from the surface of the lower lobe of the right lung, was a patch of red hepatisation about the size of the palm of the hand, and about 11 in thick. It was judged that this patch in situ would just correspond with the spot where the pain was so acute, and where the patient received the blow in falling. The author considered that the man died of pneumonia, secondary to contusion of the lung, contracted by the accident. He tried a series of experiments with a metal and wooden ring and weights, which tend to prove that if the ribs are fractured the danger to the lung may be less.

Bacteria of Puerperal Uterus.-Lea and Sidebotham (Journ. Obst. and Gyn., XV., 1).—The primary object of this investigation was to test the conclusions of those observers who maintain that the presence of hæmolytic streptococci in the vaginal or uterine secretion after delivery must be regarded as pathognomonic of the existence of infection. The results show that hæmolytic streptococci may exist in the lochial secretion without any evidence of infection. In a series of 58 cases in which the lochial secretion was examined between the second and ninth day after delivery. organisms were found to exist in the cervical canal and cavity of the uterus in 80 per cent. of observations. The organisms were mainly those which have been shown to exist in the vaginal secretion during pregnancy. Streptococci were present in 12 cases in all, 20 per cent. of the total number. In 7 instances the organisms showed no hæmolytic power, and corresponded in type to the streptococcus mitior of Schottmüller, or the S. gracilis of others. In all of these cases the puerperium was normal, except in one in-stance the temperature rose to 101.6° a few hours after the intra-uterine culture was obtained, and this is probably to be regarded as directly due to the introduction of the tube. In 5 cases hæmolytic streptococci were cultivated; in 4 of these the puerperium was afebrile throughout, but in one case febrile symptoms developed; these remained limited to a superficial infection of the endometrium. It must, therefore, be acknowledged that streptococci, indistinguishable from those found in severe forms of infection, may exist in the lochial discharge of puerperal women, even in the early days of the puerperium, without causing any rise of temperature. It is, therefore, not possible to claim that the hæmolytic forms an absolute distinction between the saprophytic and slightly virulent organisms and those which are pathogenic. If, however, hæmolytic streptococci are discovered in a case of fever after delivery, it is probable that they are the causal agents of the infection.

Hypernephroma of Broad Ligament, probably Ovarian.

—Gardner and McCleary (Surg., Gyn., and Obst., VII., 6).—The patient, set. 40, and multiparous, had not menstruated for seven or eight years. Two years

ago she noticed a tumour in her abdomen, which rose above the pelvic brim to the left of the middle line. At first there was no pain, but as the growth developed from time to time there were severe pains originating in the pelvis and radiating in all directions. Examination revealed a large, hard mass, occupying the greater part of the lower half of the abdomen and projecting into the pelvis. The tumour was very irregular in contour, and presented a distinct nodule about the size of a hen's egg on its upper anterior aspect. There was free fluid in the abdomen, and the mass displaced the uterus downwards. The abdomen was opened a little to one side of the middle line; it contained a large quantity of dark fluid. The surface of the tumour was nodular and traversed by many large veins. Owing to the numerous and strong adhesions which bound it to the pelvic and abdominal structures, much difficulty was experienced in freeing the tumour. There were several quite large cysts in the growth, and the walls were very friable. Nothing that had the appearance of an ovary was discovered, and it was presumed that the growth had started in the hilum of the ovary and extended into the broad ligament. The patient convalesced rapidly. A year later she was re-admitted to hospital with a recurrence of the tumour. On examination a mass very similar to, but not so large as the one removed was felt projecting above the brim of the pelvis to the left of the median line. On opening the abdomen a rounded mass was found in the region of the broad ligament on the left side, which measured 10 by 13 cm. It was densely adherent to the intestines, to the pelvic wall, and to the side of the uterus. The tumour was removed, and the patient was in good health, with no signs of recurrence a year later. Histo-pathology.—The oviduct which was attached to the gross specimen was perfectly normal, and although two dozen or more sections were taken from various parts of the tumour, no evidence of ovarian tissue could be found. Whether the tumour began in the broad ligament or primarily in the ovary could not be stated. Sections from the denser areas show either columns or circular islands of epithelial cells suggesting the structure of the glomerular and fascicular zones of the adrenal. The recurrent tumour was microscopically a perfect reproduction of the original growth, and indistinguishable from it. The growth was evidently a hypernephroma in the broad ligament, and probably originated in the ovary.

Temporary Ventro - Suspension of the Uterus.—Ochsner (Surg., Gyn., and Obst., VIII., 1).—The indications for this operation are on cases with large pelvic abscesses, where large denuded surfaces are bound to remain after the evacuation of the abscess and removal of the infected organs; also in cases of pyosalpinx, ovarian abscesses, old extra-uterine pregnancies, and appendical abscesses with leakage into the pelvis, in which the uterus shows a marked tendency to fall back into the pelvis when all the intraabdominal work is completed. The technique of the operation is as follows:—In laparotomies, when it seems probable that this temporary ventro-suspension will be desirable, the laparotomy incision is made so that at the lower angle the skin incision is distinctly the longest, then the fascia, and muscle, and the peritoneal wound the shortest. After the intra-abdominal work is finished, a needle armed with a double strand of ten-day catgut is introduced through the left rectus fascia about half-an-inch below the lower angle of the fascial incision, then through the left muscle and the peritoneum about an inch below the peritoneal incision. It is now passed through the uterus about an inch behind the apex of the uterus, taking a good bite and being careful not to abrade the peritoneum covering the uterus. The needle is then passed out in the reverse order on the right side to its introduction on the left, and the suture is tied just tight enough to bring the vterus in contact with the abdominal wall, but not to Cause destruction of the peritoneum from pressure. The sigmoid is now carefully placed behind the uterus and the omentum spread over this, covering all the raw surfaces which it may have been impossible to cover with peritoneum. The abdomen is then closed. most important point is to get the unabraded uterus in contact with unabraded peritoneum; then there are only two needle holes on either side where the peritoneal continuity is broken. During the years 1906 and 1907 the author performed this operation 32 times. In no case which he has subsequently examined has he found the uterus permanently suspended or adherent posteriorly. On three cases secondary operations were done about 15 months after the primary operations, all being ovarian abscess or pyosalpinx cases. In two the uterus was perfectly movable and free from adhesions. In the third the uterus was slightly adherent to the sigmoid, but fairly movable. The author maintains that by temporarily suspending the uterus in this way the objections to fixation are done away with, and the round ligaments, by being relieved of the constant overstretching due to retroversion of the uterus, regain their tone and become actively functional again in retaining the uterus in its normal position.

Eclampsia and Toxemia of Pregnancy.—Welch. (Amer. Journ. of Obst., LIX., 1). The author, quoting from Whitridge Williams, writes: "From a pathological point of view, the lesions in the two conditions differ so markedly that I do not see how it is-possible for anyone who has once observed them to consider that they are at all related. In eclampsia, as was first pointed out by Jurgens, Schmorl, and others, the lesion consists in hæmorrhagic necrosis occurring in the portal spaces, dependent upon thrombotic processes in the smaller portal spaces, and their mere presence justifies the diagnosis of eclampsia. On the other hand, in the liver lesions accompanying the toxæmic vomiting of pregnancy, the changes are purely degenerative in character, and begin in the central vein of the lobule and gradually extend to the periphery." The other school, viewing the subject from the standpoint of chemical analysis of the products of metabolism excreted in the urine, consider the different forms of toxemia of pregnancy, including eclampsia, as very closely related, if not identical, conditions. The author records the history and pathological findings of twelve cases in which the diagnosis was made either of eclampsia or toxæmia of pregnancy. The bases of the diagnosis were the clinical manifestations exhibited before death. Ten of the cases were diagnosed eclampsia and two toxemia of pregnancy. On making a survey of the liver lesions, they are found to fall into four classes. The first class had hæmorrhagic changes in and about the portal spaces and contained six cases, four diagnosed as eclampsia and two in which no convulsions occurred, and were called toxæmia of pregnancy. The second class showed necrosis in the centre of the liver lobules. These cases clinically were called eclampsia, having had from eight to over fifty convulsions, and all died post-partum on the 3rd, 6th and 6th days respectively. The third class included one case of eclampsia; the liver showed no hæmorrhage, but a general swelling of the cells and autolysis. The fourth class, in which the liver changes were very slight, cloudy swelling of the parenchyma, with no hæmorrhage or necrosis contained, had cases both diagnosed eclampsia. kidneys in all cases showed very marked disintegration of their epithelium to about the same degree. parenchyma was markedly affected throughout the organs in all the cases, but varied in different parts of the same organ. Most of the cases showed considerable hæmolysis. The masses described as fibrin in the hæmorrhages of the liver did not appear as clearcut fibrins, but have a hyaline appearance, like fused red blood-cell stromas. The condition found in the parenchyma cells indicates the action of some dissolving poison, also capable of attacking the endothelium of the blood vessels. The author suggests that the numerous hæmorrhages are due to a poison circulating in the blood, which causes agglutination of the blood-cells, which then form emboli, and by solution of the endothelium allow the blood to escape. The poison causing this serious intoxication is probably an enzyme or combination of enzymes. Two possible sources are proposed for the poison—one the kidneys and intestinal tract, the other the placenta and fœtus. The author seems to incline towards the former; he concludes that under apparently similar conditions one

individual will, while another will not, have eclampsia, and thinks this fact may be explained by the side chain theory of immunity.

F.

Cardiac Disease as a Complication of Pregnancy.—Ryder (Amer. Journ. of Obst., LIX., 1). The author reviews the records of cardiac disease complicating pregnancy at the Sloane Maternity Hospital. 4,000 confinements between September, 1904, and April, 1907, he collected 56 cases of cardiac disease; this makes a frequency of 1.4 per cent. In 5,000 confinements immediately preceding this series 36 cases of cardiac lesions were recorded, but in this series many of the milder cases were not recorded. These two series give a total of 92 cases. Mitral insufficiency was most frequent, 49 cases (53 per cent.), mitral stenosis 14 (15 per cent.), double mitral 15 (16 per cent), total mitral lesions 78 cases (85 per cent.), myocarditis 5 cases (5.4 per cent.), aortic insufficiency and aortic roughening 3 cases each (3.2 per cent.), malignant endocarditis with ulceration 1, marked tachycardia 2. The total maternal deaths in the series of 92 cases was seven (7.6 per cent.), three were with myocarditis, two th mitral insufficiency, one with double mitral, and one with malignant endocarditis. All the deaths occurred after labour, and, with one exception, within a few hours. In 32 of the series there were absolutely no symptoms. In 24 slight symptoms, calling for no treatment. In 8 treatment was necessary for obstetrical Thus in 64 cases no treatment was complications. needed for the heart lesions. In 28 cases there was failing compensation and treatment was needed. All the maternal deaths occurred in this number seven in 28 cases (25 per cent.). There were in these 28 cases 13 foetal deaths and 22 premature endings of pregnancy, but all artificial. A study of these cases show that the frequency of heart lesions in pregnancy was 1.4 per cent. Mitral lesions were by far the most common, nearly 5 per cent. Myocarditis the most fatal. Mitral stenosis and aortic lesions caused no deaths. Premature labour or abortion was common, about one in twelve, where there was no interference. The author draws the following conclusions: -Cardiac disease is a frequent complication of pregnancy. The crucial point to be considered is whether or not the heart is well compensated. During pregnancy the patient should be guarded against sudden chilling, as this is apt to cause congestion of the lungs and kidneys, and thus throw extra work on the heart. During labour great care should be taken not to let the patient over-exert herself. The first stage should be shortened by bags or bougies, and the second stage especially hastened by forceps or other means. As to chloroform, these patients stand amount well, and are benefited by it, prolonged use is harmful. With any tendency to pul-monary congestion ether is contra-indicated. With failure of compensation, under the most favourable conditions and the best treatment, the maternal mortality is 1 in 4, and the fœtal about twice as much. Treatment should not be delayed; the patient should be put to bed on light diet and heart stimulants. If, in spite of treatment, failure of compensation is more marked, termination of pregnancy should be considered. During labour the heart must be strengthened and supported, the patient quieted, and labour shortened. Morphine in small repeated doses is especially useful, as it lessens the pain, quiets the patient, and steadies the heart. Bags to hasten the first stage are useful, and forceps should be applied as soon as they can be used safely. The third stage may often be shortened with advantage. After labour, within a few hours is the time most fatalities occur. The patient should be placed in bed as soon as possible. Heart stimulants should be freely used as indicated. Morphine is of the greatest value; a full dose immediately after labour does more good than almost any other drug.

A Typhoid Carrier.—Cochrane (R.A.M.C. Journ., February, 1909) details the investigation of an outbreak of enteric fever at Aldershot during last year in which the infection was traced to a "carrier." Four patients were admitted to hospital with enteric fever during the

first three weeks of September from the 1st Battalion of the East Kent Regiment. These patients occupied adjoining rooms in the same barracks, but had recently been on furlough, and were believed to have brought the infection with them to barracks on their return, as no likely source of infection could be detected in the barracks During the following month 123 men of another regiment were accommodated in these barracks in rooms adjoining those from which the patients had previously come. These men, though occupying these rooms, were provided with a separate cook-house. Two of them eventually sickened with enteric fever. It then became evident that the infection of all the cases was probably derived from the special rooms the men occupied, for there was no tendency of the disease to spread to other men whose food supply was derived from the same source. It was then found that out of the two companies which occupied these rooms nine men had recovered from enteric fever on dates varying from 1895 to 1907. Cultures were made from the urine of each of these men, and from one of them a bacillus was recovered which proved to be the bacillus typhosus. This man had left hospital after an attack of enteric fever in November, 1904. It was found that since that time some ten or twelve men who were associated with this man had developed enteric fever. This man has now been isolated and is undergoing treatment, so it will be interesting to see if his removal will check the incidence of the disease in the company with which he was connected.

The Spirochæta Pallida and Congenital Syphilis.—M'Intosh (Journal of Pathology and Bacteriology, January, 1909) publishes a careful study of the distribution of the spirochæta pallida in the body in congenital syphilis. It is to be found in greatest numbers in the liver, but it is also present in the lungs, the spleen, the suprarenal gland, the kidney, and the skin. In the skin, as in the liver, it is in enormous numbers. M'Intosh failed to find it in the placenta or in the umbilical cord. He argues that the infection is maternal, that the spirochætes are carried in the blood to the liver, where they multiply, and whence they are distributed to the rest of the body. The organism has a special affinity for structures of the nature of consective tissue or glandular epithelium, and it is specially plentiful in the connective tissue round blood vessels. The relation of the spirochæte to congenital syphilis is very constant, and, admitting its causality, the presence of the organism furnishes an easy diagnosis.

Human Glanders .- Bernstein and Carling (British Medical Journal, February 6th, 1909) report six cases of glanders in the human subject, and discuss the methods of diagnosis. They believe the disease to be much more common than would appear from the statistics of the Registrar-General. The symptomatology of the disease is very variable, and the authors believe that the mere fact of a patient's occupation being such as to bring him into contact with horses, and the occurrence of a chronic inflammatory lesion of the oral or nasal mucous membrane, or of an inflammatory mass in the subcutaneous or muscular tissue, should be sufficient to suggest the disease to the surgeon's mind. In diagnosis, reliance is to be placed on the mallein test, both positively and negatively. Occasionally the reaction may be severe—pain, malaise, and a rigor being among the phenomena noted. The dose used was the usual one for horses-10 to 15 minims. Animal inoculation also gives information. Adult male guinea-pigs should be employed, the inoculation being intraperitoneal or subcutaneous. It is difficult to find the bacilli in smears from the pus of glanders, as they are difficult to stain, and negative to Gram's method. On the other hand, cultures grow easily and are characteristic. The authors attempted to apply the agglutination test in one case, but did not obtain any definite results.

#### THE MEDICAL PRES

#### MEDICAL NEWS IN BRIEF.

#### The Dental Hospital of Ireland.

The annual meeting of the supporters of and subscribers to the Dental Hospital of Ireland was held during the past week, when the Honorary Secretary, Mr. G. M. P. Murray, and the Dean, Dr. A. Baker, were able to present satisfactory reports of the work done by the hospital and of the school. The Dean referred in his report to the necessity for completing the building of the hospital during the coming summer, as, in consequence of want of space, they were obliged to turn away students. The necessary space for the proposed additions had been got from Trinity College, and all that was wanted was the £2,500 which the additional building would cost. The Chairman of the meeting said that the extension was absolutely necessary, and they were most anxious to begin it.

#### Compulsory Irish in the New National University.

WE published last week a memorial, signed by some 73 students of the Catholic University School of Medicine, protesting against compulsory Irish in the new University. A counter-memorial has now been issued and signed by some 200 students in the following terms:—

"We, the undersigned students of the Catholic University School of Medicine, present the following memorial to the Senate of the National University of Ireland:—We earnestly desire that the Irish language may be recognised as a fundamental element in the Higher Education of Irish Students. We, therefore, urge that a knowledge of Irish should be required of all Irish students at entrance to the University, and that the fullest opportunities and inducements be offered to students to continue the study of Irish in the University. We are also of opinion that a knowledge of Irish History should be required side by side with that of the Irish language."

#### Late Chieroform Poisoning.

THE evidence given at an inquest on February 19th concerning the death of Dorothy Abery, the six-and-a-half years' old daughter of a labourer living at Rochford, Essex, showed that the child had been unable to speak or walk from birth, and on February 19th was removed to the Great Ormond Street Hospital for Children. An operation under chloroform was performed on the child's throat. It was successful, and the girl made satisfactory progress till the next day, when she became ill, and died in 24 hours. Dr. Gray, Medical Superintendent of the hospital, said that a small dose of chloroform was administered. Death ensued from coma and heart failure, due to delayed chloroform poisoning, whilst the child was of low vitality. Mr. Schröder (the Coroner): The question of delayed chloroform poisoning has not been established many years? Dr. Gray: That is so. It was not due to the quantity of chloroform administered, but to the condition of the patient. A verdict of death from misadventure was returned.

#### Cocaine Poisoning in a Child.

An inquest was held at Derby, on February 18th, concerning the death of Rose Earl, aged 8 years. Dr. Flora Morrison said it was decided to use a local anæsthetic for removal of the tonsil in consequence of the child's low condition. Witness painted the tonsil, but the operation was performed by Dr. Shepherd. The Coroner: Was a portion of the cocaine swallowed by the child?—Not swallowed; it would be absorbed. And in consequence get into the intestines —No, into the general circulation. What effect would that have on her?—It would have a weakening effect upon the heart. What quantity of cocaine would stop the circulation of the heart's action?—I should think there would be three-quarters of a grain in this case, not more. Witness added that Dr. Shepherd removed the tensil in witness's presence. The child was not unconscious at any time. She was a little frightened at the thought of the operation, but recovered after it was performed. She then became perfectly rigid in an

epileptic fit, and sank into unconsciousness. She had ten fits altogether after the operation, and died in one. The Coroner: What would bring about these fits?—The absorption of cocaine. Would three-quarters of a grain be sufficient to kill in a normal case?—No; but this was not a normal case. The operation was properly and skilfully performed. The cause of death was the absorption of cocaine, and the operation proper had nothing whatever to do with it. Dr. Shepherd entirely agreed with the previous witness, and added that it was most unusual for three-quarters of a grain of cocaine to kill. The jury returned a verdict in accordance with the medical testimony, and added a rider to the effect that everything was done that was possible, and that no blame attached to anyone

#### National Tuberculosis Conference.

The concluding day of the National Conference on Tuberculosis, at the Caxton Hall, Westminster, was formally opened by Lord Kinnaird. Sir John Kirk presided. Lord Kinnaird said, in regard to the milk supply, that it was with considerable interest they awaited the publication of the text of the measure dealing with that matter mentioned in the King's Speech at the opening of Parliament. It was essential that the general public should be better informed on the subject of tuberculosis before any attempt was made to introduce such reforms as compulsory notification. He also referred in appreciative terms to the work done by Lady Aberdeen in Ireland. Dr. Rutherford, M.P., said that a great deal could be done in such matters as housing and town planning, and in restricting the alcoholic environment of the people. In the Poor-law Report there was the foundation for legislation in the future which would help in the protection of the children, on whom depended the prosperity of the race. At the afternoon session other papers were read, and a conversazione was held in the council chamber in the evening.

#### The Late Mr. W. H. Kendall.

On the 18th ult., additions to the Lying-in Hospital, Kingsdown, Bristol, were dedicated by the Bishop of Bristol, accompanied by Archdeacon Stewart, Canon Everingham, Canon Talbot, and others. Dr. Elliott explained that a portion of the additions to the building was known as the "Kendall Memorial," in memory of Mr. Kendall, who was recently honorary surgeon of the institution, and through whose instrumentality the extensions had taken place. A tablet in one of the wards bears the following inscription:—"This tablet gratefully records seven years' honorary faithful and efficient services rendered to the patients of this institution by Herbert William Kendall, F.R.C.S., L.R.C.P., who fell asleep December 22nd, 1906, aged 39. This ward has been furnished by grateful patients and friends as a mark of esteem."

#### The Royal Society of Medicine.

THE following members of the Odontological Section of the Royal Society of Medicine were elected as Officers and Councillors for the year 1909:—

President.-Leonard Matheson.

Vice-Presidents.—Resident: H. Lloyd Williams, C. F. Rilot, A. Clayton Woodhouse. Non-Resident: Martin Henry (Folkestone), J. McKno Ackland (Exeter), Edward Bogue (New York).

House and Finance Committee.—H. Lloyd Williams. Library Committee.—Ashley Densham.

Curator.—J. F. Colyer.

Editorial Committee.—A. Hopewell-Smith.

Hon. Secretaries.—J. Howard Mummery (Foreign), H. W. Trewby (Council), Douglas P. Gabell (Society).

Councillors.—Resident: Alfred Stevens, Norman G. Bennett, W. S. Nowell, F. Lawson Dodd, W. J. May, J. G. Turner, J. Lewin Payne, H. E. Cribb. E. B. Dowsett. Non-Resident: F. C. Porter (Nottingham), J. Royston (Liverpool), W. E. Margetson (Dewsbury), Herbert Williams (Londonderry), G. A. Peake (Cheltenham), W. de C. Prideaux (Weymouth), C. A. Havman (Bristol), G. R. Shiach (Elgin), S. G. Yates (Hereford).

#### NOTICES TO CORRESPONDENTS, &c.

Commercements requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Institut, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule. SUBSCRIPTION &

SUBSCRIPTIONS.

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TERMO.—The origin of the association of the ancient professions of the barber and the surgeon took place in 1163. Up to that time surgery, such as it was in Europe, was almost entirely in the hands of the Jews and the olergy. The clergy employed barbers as their assistants in the application of baths and oluments, and hence in the performance of such surgical operations as they were in the habit of performing. In 1163, however, the clergy were prevented by a Papal prohibition from undertaking any operation which involved the shedding of blood. The Jews had largely disappeared, probably owing to the increasing prejudice against their race, and so the barbers were left as a class with a certain familiarity with surgical technique and connection with the art. The only trace of this alliance that now remains is the barber's sign, the red and white striped pole, which is the symbol of the barber in his surgical, not in his tonsorial, capacity. In the days of blood-letting the barbers displayed outside their shops the staff which the patient grasped in his hand during the operation, wrapped round with the blood-stained bandages, and these actualities were later replaced by the symbolic emblem which still adorns our streets.

The "Lemco" or Liebig's Extract of Meat Company, Ltd., offers

replaced by the symbolic emblem which still adorns our streets.

The "Lemco" or Liebig's Extract of Meat Company, Ltd., offers a Thermos flask to clients on condition of their receiving before December 1st, 1909, weight coupons, to be found under the capsule of each jar, representing 7-lbs, of Lemco, when the flask will be sent by return. The flask may be sent sooner by sending 5-lbs, weight coupons and a returnable deposit of 7s. 6d. The flask is worth £1, and the scheme represents commendable enterprise on the part of this well-known firm.

A. B. V.—We are sorry to say we never heard of it. Probably it has not yet reached a position other than experimental.

#### Meetings of the Societies, Tectures, &c.

WEDNESDAY, FEBRUARY 24TH.
HUNTERIAN SOCIETY (London Hospital, Whitechapel Road, E.).—
p.m.: Clinical meeting.
ROTAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Fields, V.C.).—5 p.m.: Prof. W. Wright: The Morphology and Variation W.C.).-5 p.m of the Skull.

5.15 p.m.: Lecture: Pr. L. Williams: Some Climacteric Disturbances.

North-East London Post-Graddata College (Prince of Wales's General Hospital, Tottenham, N.)—2.30 p.m.: Gynecological Operations (Dr. A. E. Giles). Clinics: Medical Out-parient (Dr. A. J., Whiting): Surgical (Mr. H. W. Carson); N. Rays. 5 p.m.: Medical In-patient (Dr. G. P. Chappel). 4 30 p.m.: Lecture: Dr. A. G. Auld: Difficulties encountered in the Physical Examination of the Lungs and Heart.

St. John's Hospital. for Direases of the Skin (Leicester Square, W.C.)—6 p.m.: Clesterfield Lecture: Baldness, its Causes and Treatment.

Feidar, Ferrurar 26th.

Rotal Society of Medicine (Section for the Stidt of Disease in Children) (20, Hanover Square, W.).—5 p.m.: Cases Dr. Edmund Cautley: (1) Cerebral Dipligic Spacticity; (2) Abdominal Tuberculosis; (3) Mongolian Imbecile (2). Dr. F. J. Poynton: Case for Diagnosis. Mr. Nother Stephenon: Plexiform Neuroma involving the Right Parietal Region and Right Upper Evelid. Dr. O. F. F. Grundbaum: Case of Hirschsprung's Disease, Discussion: On the Medical Examination of School Children Opposed by Dr. George Carpenter).

BOTAL SOCIETT OF MEDICINE (EPIDEMIOLOGICAL SECTION) (20, Hanover Square, W.).—8.30 p.m.: Dr. H. de R. Morgan and Dr. J. C. G. Ledingham: The Bacteriology of Summer Diarrhoea Dr. J. C. G in Children.

in Children.

ROYAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Fields, W.C.).—5 p.m.: Prof. W. Wright: The Morphology and Variation of the Skull.

MEDICAL GRADUATES COLLEGE AND FOLYCLINIC (22 Chenics Street, W.C.).—4 p.m.: Dr. J. Horne: Clinique (Throat).

NOBTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 5 p.m.: Medical In-patient (Dr. R. M. Leslie).

CENTRAI, LONDON THEOAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. Abercrombie: Pharynx and Nasopharynx.

TUESDAY, MARCH 2ND.

pharynx.

TUESDAY, MARCH 2ND.

ROYAL SOCIETY OF MEDICINE (THERAPEUTICAL AND PHARMACOLOGICAL SECTION) (20, Hanover Square, W.).—4.30 p.m.:

A Discussion on the Treatment of Spasmodic Asthma, to be
opened by Dr. Cecil Wall.

BALLANTINE, S. A., M.B., Ch.B.Edin., F.R.C.S.Edin., Honorary Surgeon to the Coventry and Warwickshire Hospital. CARY, ARTHUR JAMES, L.R.C.P., L.R.C.S., L.M.Irel., Medical Officer for the Fourth District of the Axbridge (Somewet)

Ufficer for the Fourth District of the Arbridge (Somerfiet)
Union.

FURBEY, F. R., M.B., C.M., Clinical Assistant to the Chelsea
Hospital for Women.

GLENDINING, BRIDEN, M.B., B.S.Durh., F.R.C.S.Eng., Pathologist
to the Chelsea Hospital for Women.

LECRE, ARTHUR. M.R.C.S., L.R.C.P.Edin., Medical Officer of
Health of Arbridge (Somerset).

MOORE, C. A., M.S., M.B.Lond., F.R.C.S., Senior House Surgeon
at the Bristol General Hospital.

PINEO, ERNEST GEORGE DUUGLAS, L.R.C.P.Lond., M.R.C.S.,
Medical Officer for the Churchill District of the Arbridge
(Somerset) Union.

ROSS, DONALD, M.B., Ch.B.Edin., Assistant Medical Officer at the
RONBURGH DISTRICT ASPURM, Melrose.

SCOTT, MALCOLM L., M.B., Ch.B., Clinical Assistant to the Chelsea
Hospital for Women.

#### Vacancies.

Parish of Gairloch (Southern Division).—Medical Officer. Salary, £150 per annum. Applications to the Clerk to the Parish Council, Poolewe.

County Palatine of Chester.—Medical Officer of Health. Salary, £750 per annum, with travelling and hotel expenses. Applications to Reginald Potts. Clerk to the County County Offices, Northgate Street, Chester.

Rhondda Urban District Council.—Assistant Medical Officer of Health. Salary, £250 per annum. Applications to W. P. Nicholas, Clerk to the Council, Council Offices, Pentre. Rhondda.

Cancer Hospital (Free), Fulham Road, London, S.W.—First Assistant to the Research Department. Salary, £350 per annum. Applications to Fred. W. Howell, Secretary.

Durham County Asylum.—Junior Assistant Medical Officer, Salary, £150 per annum, with board, laundry, and attendance. Applications, immediately, to the Medical Officer of Health. Salary, £500 per annum. Applications to H. J. Baker, Clerk to the Council. Council House, Houselow.

York Dispensary.—Resident Medical Officer. Salary, £130 a year, with board, lodging, and attendance. Applications to Dr. Swanson, The Pleasaunce, Heworth, York.

#### Births.

Cowan.—On February 19th, at 32, Fitzroy Square, London, the wife of Dr. Horsee Cowan, of a daughter.

MASINA.—On Feb. l. at Warden Road, Malabar Hill, Bombay, India. the wife of H. M. Másiná, F.R.C.S., of a son.

#### Marriages.

ORTON-COATES.—On Feb. 20th, at Eye Church, Leominster, Ernest Henry, youngest son of G. H. Orton, M.B., F.R.C.S., of 7 Campden Hill Road, Kensington, to Fmily Beach, second daughter of C. W. Coates, of Osborne Park, Belfast.

#### Beaths.

ALL.—On February 20th, at Cannes, of pneumonia, Dr. Robert Henry Coall, late of 65, Brook Street, Grosvenor Square.

Henry Coall, late of 65, Brook Street, Grosvenor Square, London.

FLEMING.—On Feb. 19th, at Clyde Lodge, Caterham Valley, Robert Gage Fleming, M.D., late of Thornton Heath, aged 61.

Hamilton.—On February 19th, at 35 Queen's Road, Aberdeen, David James Hamilton, M.B. LL.D., F.R.S., Emeritus Professor of Pathology in the University of Aberdeen, fessor of Pathology in the University of Aberdeen, Mrs.—On February 17th, at 17 Gloucester Walk, Campden Hill, Thomas Radford King, F.R.C.S., M.D., from heart failure, after three days' illness, Routh.—On February 19th, at 52 Montagu Square, London, Charles Henry Felix Routh, M.D.Lond., M.R.C.P., aged 87, Styton.—On February 17th, at 37 Denbigh Street, Warwick Square, London, in her 96th year, Charlotte, widow of John Sutton, Esq., M.R.C.S.

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(Signed) ——, L.R.C.P., L.R.C.S., &c.

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(Signed) ---, L.R.C.P., L.R.C.S.

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Frank Van Fleet, M. D., Professor Diseases of the Eye, Post-Graduate Medical School and Hospital, New York: "I was unfortunate enough to contract double Pneumonia last winter, which was followed by double Pleurisy and Empyema. During several weeks of unconsciousness I was nourished (after milk had begun to disagree with me) with Valentine's Meat-Juice exclusively."

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## THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, MARCH 3, 1909.

No. 9.

#### Notes and Comments.

THE breakdown in the administra-The Deadlock tion of the Midwives Act is deplorin the able, but the blame certainly does Midwives Act. not lie upon the medical profession. Parliament has rarely, if ever, been generous, let alone just, where the payment of medical services is concerned. The last notable instance in which the Government exacted purely gratuitous work from medical practitioners was in the notification of births, which is not only an unpaid, but a compulsory duty. The fact is gradually becoming known, however, that Parliament made a fatal error in not fixing for the payment of medical men called in to the help of that newly-created hybrid practitioner, the certified midwife. There is a limit even to the open-hearted generosity of the medical profession, and it can hardly be wondered if the average practitioner declines to attend at a midwife's behest a case where his fees are not guaranteed. A valuable source of his modest income has been diverted into unquali-fied channels, and it is asking too much of human nature to demand his skill and services without proper remuneration. For his skill and his time are his livelihood, a plain fact that is apparently overlooked by the public and by the legislature that have long grown accustomed to acts of selfabnegation and unselfish generosity on the part of medical men. All that has been repaid by the creation of the certificated midwife. The circumstances of the situation have been changed, and it is natural enough that the general practitioner should assert his right to revise his own attitude with regard to the vast amount of gratuitous work he has bestowed upon the woman in labour for many a year.

A Case at Sheffield. The whole question has been thrust in concrete form upon the inner consciousness of the good folk of Sheffield. A midwife who was called in attendance on a case said it was

one for a medical man, and forthwith left the house. The husband called upon four medical men, none of whom would attend unless the fee was forthcoming. Soon after his return home his wife died from hæmorrhage. It is difficult to see how the midwife could be justified in leaving a woman alone under what she obviously recognised as abnormal conditions of labour. The Coroner said the refusal of the doctors to attend seemed hard, but a medical man's skill was his capital, and they gave away without hope of return more of that capital than any other profession on earth. They went to hundreds of cases where they knew they would never be paid, and to hundreds of cases where they hoped to be paid, but never received

any money. The Sheffield Daily Telegraph has taken up the subject with its usual outspoken common sense. Says that journal, quoting a medical friend:—"There are hundreds of people who regard our profession as perfectly fair game. They think they have a right to call us in whenever they like, and to pay us or not just as they choose. And it arises very largely from out own cowardice and from the thoughtlessness of those who are better off." The rest of the communication runs as under.

" Our Own Fault." "COWARDICE!" echoed the *Telegraph*. "Just that," he responded. "Many doctors have not the moral courage to refuse a call; it may mean publicity and some amount of

denunciation which they dare not face. Then, again, there are doctors who have good paying patients who never send in a bill to their poorer clients. That is all right from their point of view, but it is terribly hard on the struggling practitioner. When doctors agree to say, 'We are professional men. Pay us, and our services are at your disposal. But no pay, no service,' we shall come to the end of this noxious business. But I do not blame the public. I blame my own colleagues. It is our own fault." The fact is, comments the editor, that a doctor is a professional man, just as a lawyer is, or a chartered accountant, or an electrical engineer. And he has a perfect right to demand payment for what he does. Whether a doctor would be right to refuse to go in answer to this particular call or that is a matter of individual circumstances. But he can do so if he choose. If he did so a little more frequently, and in some sort of combination, it is probable that the need for doing so would quickly disappear.

THE late Lord Beaconsfield, in his The dry epigrammatic manner, once re-Manifesto marked that he set no more store by Authoritative manifestoes than by the remarks chalked up on walls by urchins in the street. Like all epigrams, this expresses a certain side of the truth, and that side, we take it, is that the manifesto bearing the highest names is seldom representative of more than one phase of opinion, and is never final. At the same time, it is undeniable that such manifestoes must, and do. decidedly influence public opinion, and it is absolutely necessary sometimes to issue, as we ourselves did in the case of the late pro-alcohol manifesto, a counter-blast to show that authoritative opinion is not always on the same side. We have lately had another document, this time not technically a manifesto, but a signed letter, going the round of

the press, containing the condemnation by certain eminent members of the profession of long-distance running for school-boys. We cannot think that this method of "educating" the public is altogether happy or quite dignified. In the first place, it lays the signatories under the imputation of wishing to keep their names under the public eye, and even if done with the purest motives, there are always plenty of people ready to attribute this human failing to those who use the method.

Its Dangers.

THEN, again, after all, it merely expresses the opinion of the individuals signing, and the public are unable to judge whether in the question submitted the signatories are really

the right people to rely on. To them the fact that a man holds a Court appointment and has been dubbed knight or baronet is far more important than that he should have had actual large experience in the particular matter at issue. Moreover, there is a certain over-riding of the opinion of those-perhaps equally competent to judge (hence the value of counter-manifestoes)-who think differently. And, finally, the question cannot be discussed in the available limits of space in a manifesto, and consequently only a single argument or a blunt expression of opinion is possible. We think, then, that the leaders of the profession would be acting wisely and more in accordance with the healthy traditions of the profession if they eschewed this practice. It is an insidious one, and, like the sport of limericking, if it once gets hold of the profession, it may degenerate into a positive vice. Every medical man has his own opinion on medical subjects, and is entitled to it, but there is no reason for him to try to get it accepted, to the exclusion of those of his brethren, by being the first to "get it into the papers."

Mr. Lupton, M.P., has as sharp a Syphilisation nose for vaccine as ever Judge and Jeffreys had for a traitor, and last the Navy. week he unearthed one which should go far to recompense him for a

hundred snubs. It appears that last summer, at the annual meeting of the British Medical Association, a naval surgeon read a paper on anti-syphilitic inoculation, and he is said to have made the suggestion that men entering the Navy should be offered the opportunity of thus rendering them-selves immune to that disease. This was something after Mr. Lupton's own heart, especially as the virus was to be obtained from anthropoid apes, and he concocted a question to draw the First Lord, and it did, in fact, to some extent succeed, for it would appear that naval surgeons have to obtain their chief's approval before publishing scientific papers. That such a rule should exist is, we think, a pity, as in a liberal profession a man may differ very widely from current opinion, and yet should be allowed to express his views for what they are worth without implicating any-body but himself. That way progress lies. If medical science is to advance in the Army and Navy, it is obvious that many subordinates will differ from their superiors, without proper discipline or efficiency suffering.

Duties of Director-General.

THE duties of the Director-General of the Medical Department of the Navy should, therefore, be confined to the administrative side, and the purely scientific left, with due encouragement, to the enthusiasm of his subordinates. He should in no sense be bound, or associated with, views-heretical or ortho-

dox-published as scientific contributions by his officers. In the matter in question the naval surgeon who read the paper probably knows from practical experience far more of the horror and misery wrought by syphilis among bluejackets than Mr. Lupton or Mr. McKenna, and probably has given infinitely more thought to its prevention than either of these gentlemen. Even as civilians we know that the results, immediate and remote, are appalling. So that, without committing ourselves to any specific view of the proposed remedy, we may go so far as to say that it will be more becoming in them to criticise the officer when they have devoted as much attention to the subject as he has. Any honest effort, however mistaken, to prevent the gigantic evil, is deserving, at least, of respectful consideration.

#### LEADING ARTICLES.

#### PAYING PATIENTS IN CHARITABLE HOSPITALS.

The moot question of the propriety of the reception of paying patients in the wards of charitable medical institutions has been brought to the front in Liverpool, where recently a discussion has been raging on this debatable point. It was inaugurated at the annual meeting of the Royal Southern Hospital, held at the Town Hall on February 8th. On that occasion Mr. Charles W. Hayward, operating surgeon at the Hahnemann Hospital, called the attention of the trustees to the fact that in the Southern Hospital there were private wards to which private patients were admitted on a payment of two guineas a week for board and maintenance. but nothing was paid to the members of the medical staff who attended these cases. These patients, according to him, were all, or nearly all, prepared to pay. Several of them bore good names in Liverpool, and were thus under the stigma of receiving charity from the medical officer, if not from the hospital. Mr. Hayward dissented from the statement of Mr. Adamson, the President, to the effect that only the right class of case was admitted. This partial attack on the natural order of things produced an equally strong and pointed defensive reply on the part of the President. The latter read from a circular sent to every applicant for attendance in the private ward the following extract:-" The private wards of this hospital are for the use of poor persons who can pay two guineas per week towards their nursing maintenance, but who are unable to pay the specialists' fees for the treatment necessary for their cure. Persons who can pay those fees for treatment at home or a nursing home are not eligible for admission." That ground is intelligible enough, whatever view may be taken as to the justice of the transaction. Mr. Adamson, however, proceeded to make some general remarks upon the relation of honorary medical staffs to the hospitals which we are happy to think are not commonly introduced into public discussion by the chairmen of those institutions. After mentioning the fact that every patient admitted to the private ward was introduced by a member of the honorary staff or by a resident officer by arrangement with an honorary officer, he attacked the proposal to pay the medical attendants. It would be a "crying shame," he is reported to have said, if the medical man who used the hospital theatres or implements,

and took up the time of the nurses, should make any charge to the patients. We should like to ask Mr. Adamson is the hospital has any greater right to trade upon the theatres, and wards, and implements, and the nursing staff, to make money out of paying patients? The money having been subscribed to an institution for clearly-defined charitable purposes, it is not easy to see how the diversion of an eleemosynary gift to the forwarding of a purely business transaction can be justified. Least of all can we understand the line of reasoning which argues that everyone in the hospital concerned with the treatment of the paying patient—that is to say, house-surgeon, dispenser, nursing and domestic staff-should be paid, with the sole eception of the medical man, whose services are the central and indispensable proof of the whole affair. If, following the President's example, we reverted to plain English, the transaction might be described as "sweating" the honorary medical staff for the benefit of the hospital. The rest of Mr. Adamson's remarks were probably uttered in haste, for they seem hardly consonant with the dignity usually associated with the chairmanship of an important medical charity in one of the great cities of the Kingdom. He remarked that whenever a vacancy occurred on the honorary staff there was a struggle for the post among medical men. He quoted the recent statement of a London man, that it was worth £10,000 a year to get into a London hospital, to which he added-presumably his own estimatethat in Liverpool the indirect return would be £5,000. Whatever the case with eminent surgeons, either in London or in the provinces, the average income of the operating surgeon and successful specialist is certainly considerably below that mark, while that of the consulting physician has fallen of late years to an extent that has in many cases even threatened his survival. This disproportion of emolument will sooner or later doubtless lead to a readjustment of the fees and the field of work hitherto adhered to by physicians and surgeons. In any event, it is difficult to see how any responsible hospital executive can seriously defend the proposal to use the honorary services of the staff as a means of making money for the institutions concerned. The logical and right course, it has been urged in some quarters, would be to pay all medical men who serve the hospitals. There is much to be said in favour of that alternative, which appears to grow in favour with modern professional opinion. Certainly, so far as young consultants and specialists are concerned, the boon thus conferred would be in accordance not only with the diotates of common-sense, justice and propriety, but would be an inestimable aid to the first struggling years of practice. There are serious objections to the practice of the members of an honorary medical or surgical staff taking fees from patients in the pay wards of hospitals. The rights of the general practitioner are seriously invaded by such a practice, and where such an unwise usage has been established, the day of retribution will probably one day be at hand. The fact that there is no authoritative body entitled to speak out strongly and decisively on such important matters affords a striking testimony to the defective organisation of the medical profession of the United Kingdom.

THE SEQUELÆ OF MEDICAL INSPECTION.

One of the great difficulties of social reform is that it is almost impossible to predict the effect of a step ahead till the step has actually been taken, and though there are never lacking prophets of blessing and prophets of woe, their utterances have always to be discounted by the fact that no prophet can be judged except by posterity. There can be but little hesitation on the part of thoughtful people in admitting that the effects of two recent measures which were passed with general support, namely, the feeding of schoolchildren and their medical inspection, are merely stepping-stones to a vastly wider series of social responsibilities, and that the ultimate goal, which it is difficult logically to dispute, is the State care of the child. We presume that there are both good and bad sides to this ideal. The State would be better than a bad parent, but not nearly so good as a conscientious parent, and the scope of the reasonable function for the State would seem to be to encourage the latter by every legitimate means, while replacing the bad parents' shortcomings with care for the child and punishment for the offender. There, however, the question does not end, for though the bulk of parents are neither very good nor very bad, they are generally poor, and out of that poverty arises inability to do for the child what modern consideration for its welfare deems necessary. In nothing is this so well exemplified as in medical care. If doctors are to be efficient, they must be highly trained, and training of such a character as will fit a man to be a trustworthy adviser in sickness connotes a long and expensive education. So that medical attendance is bound to be expensive, at any rate, as regards the means of the unskilled worker. The problem has hitherto been carefully shunned by the State, and free charitable hospitals and the humanity of medical men have been left to do what they can for the With the advent of the systematic medical poor. inspection of school-children, however, a new and disconcerting factor has arisen. Children in shoals are found defective by the medical examiners in teeth, eyes, ears, and a dozen other attributes, and the parents receive official intimation of the fact, with a recommendation that dental and medical advice shall be sought. Three courses are open to recipients: to take no notice-which is apparently the most frequent; to call in their own doctor-which appears to be the least frequent; or to take the child to the hospital-which is sufficiently frequent to disorganise the normal routine of, at all events, some institutions. We admit the difficulty of the parent. To set in order, and to keep in order, the children's teeth is bound to be a matter beyond the means of a labourer earning As a week. Nor can it be expected that a club doctor can afford the necessary time and provide the necessary apparatus to take out the refractions of the eyes of a large number of children for whom he has to provide medical attendance and medicine at probably a penny per head per week. hospitals are already more than sufficiently patronised, and even if unsuitable applicants are winnowed out, there remain an enormous number of deserving ones who can only be dealt with as an expense which is proved to be beyond the means

charitable people are prepared to subscribe. The question of school clinics, therefore, has arisen, and whether this be the right solution or not, it is evidently one which the State, either by means of central or local authorities has to consider, and, if adopted, to pay for. A somewhat acrimonious debate took place at a meeting of the Education Committee of the London County Council last week on a proposal of the Royal Eve Hospital, which has already provided considerable facilities for treating the eyes of elementary school-children, still further to increase their accommodation if the Council would subsidise the extension. From the Council's point of view this would be a very cheap bargain, and yet the whole debate centred round the question whether they would provide the money themselves or extract it from the Chancellor of the Exchequer. That in itself is a municipal question with which we are not immediately concerned, but we do protest emphatically that if the public authority in charge of children needs medical advice for them, it is only right and fair that it should pay, whether the money comes out of taxes or out of rates. It is to us an insufferable suggestion that any public authority should cast its responsibilities on the shoulders of medical men without payment. It has been done time and again, and will be done as long as medical men allow themselves to be exploited. Members of the profession who allow themselves thus to be used are not only short-sighted in their own interests, but are betraying the rights of their colleagues.

#### CURRENT TOPICS.

## The Increase of the "Conscientious Objector" to Vaccination. When Mr. Balfour's "conscientious objector"

came into existence it was fairly evident that the species would increase and multiply when blind mothers and ignorant fathers began to comprehend the possibilities of the situation. It is so much easier for most of us to run the risk of a remote contingency like small-pox than to face the visible discomfort of vaccination. Accordingly, it is not surprising to learn, on the authority of the Northern Echo, that in the Amble and Raafe townships of the Alnwick Union there is a strong increase in the number of "conscientious objectors" to vaccination. By the return of Mr. Taylor, vaccination officer, it was shown that while there were 20 in one half of 1907, the number had increased to 147 in the corresponding half-year of 1908. When this statement was laid before the Alnwick Guardians at their ordinary meeting, one of the members remarked that a visit of small-pox would tell a sad His prophecy might have hailed from any responsible medical authority, so obvious is the scientific soundness of his surmise.

The Danger of Old Prescriptions.

The risks attendant on the use of old prescriptions are known to most medical men. Some patients not only use physic that has been ordered for them several years previously—possibly for essentially differing pathological conditions—but they go the length of hawking their prescriptions among friends——relatives. Instances have been known

in which the prescriptions of some famous surgeon or physician have been handed down as valuable heirlooms from father to son. The risk of a patient using an old prescription for the purpose of obtaining a poisonous drug is not generally recognised by members of the medical profession. A case in point occurred recently at the City of London Coroner's Court. An Italian restaurant-keeper committed suicide by means of corrosive sublimate which had been medically prescribed for him to be used as a lotion some years previously. On the strength of the prescription he obtained a bottle containing twenty-five tabloids of the drug. The Coroner pointed out that the new Pharmacy Act did not meet all difficulties. It was shown in evidence that medical men were not required to place the word "poison" on prescriptions containing deadly drugs. The chemist who dispensed the corrosive sublimate pointed out a precaution adopted by some medical men, who marked their prescription, "not to be dispensed" after a certain date. This point is worthy of careful consideration by all practitioners who are called upon to prescribe remedies, poisonous or otherwise.

Deaths by Poison.

THE Annual Report for 1907 of the Registrar-General for England gives some interesting figures regarding deaths by poison in that year. The number of accidental deaths due to poisoning was 248, as against 245 in the previous year. Of these poisons, opium, including its derivatives, was most frequently at fault, causing 70 deaths. Next to it came hydrochloric acid, which caused 17, and then ammonia 16, and carbolic acid 13. Of the less common poisons, mushrooms caused 7 deaths, poisonous berries 1, and the sting of insects 2. In addition, there were 109 accidental deaths due to poisonous vapours. Of these coal-gas came first with 51 deaths, and carbon monoxide next with 14. Of 186 deaths due to anæsthetics, chloroform caused 95, ether 10, chloroform and ether 5, nitrous oxide 3, A.C.E. mixture and ethyl chloride 2 each; the kind of anæsthetic was not stated in 69 cases. We are probably right in thinking that chloroform was responsible in most of them. Its extraordinary preponderance over ether is therefore well shown. The number of suicides by poison during the year was 530. Apparently the guiding factor in the choice of a poison was ease in obtaining it, for the three substances most often employed were carbolic acid in 93 cases, hydrochloric acid in 83, and oxalic acid in 81, substances commonly used in the arts or for household purposes. Other poisons frequently selected were opium in 60 cases, hydrocyanic acid in 33, potassium cyanide in 30, ammonia in 15, and strychnine in 13. Coal-tar was used in 1, and yew leaves in 1. In addition, coal gas was used by suicides in 63 cases, and carbon monoxide in 2. In 3 murders poisons were employed, hydrocyanic acid in 2, laudanum in 1.

#### "Reasonable Skill."

A somewhat curious civil action has been recently tried at the Sussex Assizes. It was brought against a country practitioner for damages for alleged negligence in his attendance on a lady patient. From the evidence it seems that an error

of diagnosis was committed by the defendant as regards pregnancy, and that on his account being presented legal action was taken against him, A large amount of expert evidence was brought to show that the defendant had not shown undue negligence, although it appears to have been admitted that he had omitted to use a stethoscope. The case was exhaustively dealt with, and ended in a verdict in favour of the defendant. The judge, in summing up, said what the female plaintiff was entitled to from the defendant was such care and skill as was reasonable or ordinary in the profession, and to an extent they must put aside his qualifications, because a man might be brilliantly qualified, and yet be negligent. We were all wanting in perfection in knowledge, even lawyers, and it did not follow that because defendant was brilliantly qualified he might not have been off-handed. The jury must be absolutely sure plaintiffs had made out their case before they could find in their favour. If they had a doubt, or anything short of positive certainty, the defendant was entitled to their verdict. A better appreciation of the proviso of "reasonable skill," as emphasised by his lordship, would prevent many a foolish and vexations lawsuit.

#### The Report of the Poor-Law Commission.

THE Commission on the Poor-laws and Relief of Distress considered it expedient to deal with Ireland and Scotland in separate reports, which have not as yet been issued. A forecast of their recommendations has, however, already appeared, which enables one to form a fairly definite idea of the character of the Report itself. The Commissioners state that at the outset of their inquiry they found a Viceregal Commission had lately reported on several points in connection with Poor-law administration in Ireland, and had formulated certain proposals. The Commissioners considered they were greatly indebted to this report, so much so that, while they visited Ireland to see the state of affairs with their own eyes, they did not consider it necessary to call fresh evidence. The scheme recommended by the Commissioners falls in with the view of the Viceregal Commission in the main, save as regards their proposals affecting outdoor relief and the retention of the old boards of guardians. From this it appears that the Commission will recommend the creation of a State medical service, and there will be a real prospect of the abolition of some of the worst abuses which accompany the present position of affairs, both in regard to the appointment of medical men to the service and the treatment of them when appointed. The Government can hardly shut their eyes any longer to the existing state of things or shelve the recommendations of two Commissions, and it is gratifying to learn from the lips of the Premier that "the supporters of Poor-law reform in Ireland need have no apprehension that the recommendations of the Viceregal Commission would be ignored."

#### PERSONAL.

On the 22nd ult., the Princess of Wales opened a new children's ward at the Great Northern Central Hospital in Holloway Road, London.

MR. P. A. NAIRNE, Chairman of the Committee of the Seamen's Hospital, presided last week at the first annual dinner of the London School of Clinical Medicine, held at the Savoy Hotel. Dr. W. G. SARGENT has been appointed a magistrate for the County of Monmouth.

Dr. A. F. L. Dorin has been elected President of the Metropolitan Police Surgeons' Association.

THE Gillson Scholarship in Pathology (1909) of the Society of Apothecaries of London, has been awarded to Philip Noel Panton, M.B. (Camb.).

CAPTAIN HAYWARH PINCH, F.R.C.S., Medical Superintendent of the Polyclinic, has been appointed Director of the new Radium Institute.

The name of Sir Thomas Barlow, Bart., M.D., is among those of the candidates recommended by the Council of the Royal Society for election to the Fellowship of that body.

Dr. Hugh Woods and Sir William Sinclair, M.D., gave evidence last week before the Departmental Committee of the Privy Council sitting to inquire into the working of the Midwives Act.

It is proposed to make a public subscription to present Dr. E. M. Grace, the veteran cricketer, with a testimonial on his resignation, after 40 years' service, of the post of Secretary to the Gloucestershire County Cricket Club.

MR. GILBERT BARLING has been placed on the Commission of Peace for Birmingham. He is Dean of the Faculty of Medicine at the Birmingham University, and Hon. Surgeon at the General Hospital.

Dr. R. S. Simon, Honorary Physician to the Birmingham General Hospital, has been appointed a J.P. for that city. He is cousin to the Prime Minister, whom he has entertained on each occasion that he has visited Birmingham.

MR. J. LENTAIGNE, President of the Royal College of Surgeons of Ireland, took the chair at the annual dinner of that institution on February 20th. The Lord-Lieutonant honoured the company with his presence.

A PROVINCIAL sessional meeting of the Royal Sanitary Institute will be held on March 12th and 13th at Sheffield. A discussion on "Medical Inspection—Its Relationship to the Home Life of the Children," will be opened by Dr. Ralph P. Williams, Assistant Medical Officer of Health, Sheffield.

LAST week Sir William J. Collins asked, in the House of Commons, whether any steps were to be taken with regard to "kissing the book" in the administration of oaths, and was answered by Mr. Herbert Gladstone that the matter was under consideration, now that infection had clearly been traced to that source.

Dr. Hebert, of London, has been awarded several hundreds of pounds damages against the Morning Leader, Star, Weekly Despatch and other newspapers, by way of damages for a libel stating him to have been connected with a bogus matrimonial agency in Paris. Apologies for repeating the libel have been published by a large number of journals.

SIR RUBERT BOYCE, F.R.S., Dean of the Liverpool School of Tropical Medicine, has been asked by the Colonial Office to visit the West Indies with a view to instituting reforms in the hygienic methods in practice in those islands. He is expected to arrive at Barbadoes this week.

The International Congress of Ophthalmology will meet at Naples from April 2nd to April 7th next, and not from March 2nd as was inadvertently stated in our last issue. Corresponding secretaries in the United Kingdom are Mr. Walter Jessop, London; Dr. George Mackay, Edinburgh; and Sir Henry Swanzy, Dublin.

#### A CLINICAL LECTURE

ON

#### THE PRESENT POSITION OF INTRAVENOUS TREATMENT.

By FELIX MENDEL, M.D.,

Essen (Ruhr).

[SPECIALLY REPORTED FOR THIS JOURNAL.]

PART I.

THE endovenous application of medicines has gained such a considerable importance in practical medicine during the last ten years that we must presume that every physician has a proper knowledge of the numerous indications for this method of treatment, and that he has enough dexterity to be able to make use of it secundem artem. It required a long time and manifold experiences to overcome the dread of intravenous therapeutics that long prevailed amongst medical men, although it has been firmly established for years that all the objections against this method of medication that have been brought forward again and again, and that it is dangerous in practice, have no scientific and practical basis. It has been fear of air embolism that even to the present day has kept back the majority of physicians from making use of Then, also, with the development of bacteriology and the doctrine of anti- and asepsis, came the fear that an injection not perfectly aseptic might set up a general section and personal section are general section as personal section and guarantity of air, even when it penetrates into a vein, To-day we know that a small which, however, can be easily avoided, is absolutely free from danger to the circulation. There is, therefore, no fear of air embolism, or it can be excluded

with absolute certainty.

Septic infection is still less to be feared in our method of treatment, for the operation is so simple and slight that it can be performed aseptically even without much attention. Then we have also learned that when, even in spite of care, a few micro-organisms find entrance into the blood-channels, they are easily made innocuous and removed from the system by the bacteriolytic and anti-toxic properties of the blood, when they might be dangerous if admitted by subcutaneous injection, as they would then have the opportunity of settling in the tissues and forming centres of suppuration, which would constantly be sending fresh infective material into the system. On these grounds we are in a position to formulate the following—contrary to the views hitherto current—that, cateris paribus, a subcutaneous injection can be more dangerous to the recipient than an intravenous one.

A striking proof of the correctness of these deductions is furnished by the fact that, in spite of its manifold employment, not a single case of general infection and fatal embolism has been reported after the intravenous application of medicines, an experience that I can fully confirm after thousands of intravenous injections of my own. Of course, proper selection of the medicaments to be made use of is of great importance, and also a specially cautious dosage, along with careful consideration of their pharmacological properties. Medicines that can be used intravenously without danger, and so avoid any local and general mischief, and, above all, thromboses and emboli, must have the three following properties:—

(1) They must not set up any coagulation of the fluids of the blood.

(2) They must not in any way injure the corpuscular elements of the blood.

(3) They must not injuriously interfere with the normal function of the endothelium of the veins, as only a healthy vein wall can prevent the formation of thrombi.

It will naturally also be understood that all medicaments are to be excluded from intravenous injection that may choke the capillaries either by their consistence, their aggregate constitution, or admixture of bodily elements.

If a medicament fulfils these conditions, the intra-

venous administration of it may be said to be free from danger, apart from its pharmacological and dynamic properties; it therefore possesses great advantages over all other kinds of medication.

In the case of internal administration the medicines undergo so many changes during the progress of digestion, before they reach the circulation and begin their work, and are so often so imperfectly absorbed owing to the condition of the digestive tract, that the dose actually taking effect cannot be calculated beforehand, and it does not enter into action either quickly or with certainty. Then we must take into consideration a direct injury to the digestion by the medicine, an evil that not only has a bad effect on the general condition of the patient, but not infrequently retards the absorption of the drug, and makes it impossible to carry out the treatment by internal means.

From this point of view subcutaneous and intramuscular injections are a distinct advance, in contrast to internal administration, and in many cases they may even take the place of intravenous infusion.

But there are a number of substances that, if injected subcutaneously or into the muscles, set up such strong symptoms of local inflammation as to make their employment not only difficult, but it altogether delays or prevents their absorption. As such substances are in many cases suitable for intravenous injection, this, if we do not go back to administration by the mouth, is the only way possible.

With intravenous injection the medicine at a stroke both gets into the blood current and in full dose, where it may act with much more energy than by any other mode of administration. The experiences of the last ten years prove this, and the most recent experiments fully confirm it. The theoretical objection that this energetic action is of only a short duration, and that the rapid entrance into the blood channels necessitates a rapid expulsion, has been shown to be unfounded, since my own searching experiments (Felix Mendel, Therapie d. Gegenwart, 1908, July) on the excretion of medicines administered through the veins, especially sodium salicylate and potassic iodide, have determined that the intravenous injection of medicines rather retards than accelerates their excretion, that therefore the strikingly heightened therapeutical effect depends on the combined effect of two components, on the simultaneous entrance of the full dose of the medicine into the blood tract and its retarded elimination. But all objections that have been raised over and over again against intravenous treatment, and have stood in the way of its spread, are refuted in an especially thorough manner by the historical development of our method of treatment.

The direct infusion of medicines into the blood tract was already made use of in the first half of the last century—that is, long before the teachings of antisepsis had robbed our operative measures of the greatest part of their terrors—frequently with good success, especially in such diseases as threatened life, where the act of swallowing was prevented by spasm or unconsciousness on the part of the patient, and nucdicines could not be got into the system in any other way. In such cases, along with the unavoidable venesection, the intravenous injection of tartarised antimony and other emetics played an important part, and often had a life-saving effect, judging from the accounts given of the cases. But a number of other medicinal substances were also given in the way of infusion, such as the narcotics, belladonna, opium, morphia, chloral. Yea, even the insoluble camphor, mucilage, atmospheric air—things that with our pre-

sent physiological knowledge we should scarcely dare to make use of. But the names of those physicians that made use of these drugs, and their recognised capabilities as observers, are a sufficient guarantee that this method of giving medicines had no dangerous consequences as regarded the patient. From the imperfect instrumentarium of the time, the infusionto-day so simple-must have been a serious surgical undertaking. The wound rarely healed without sup-puration, and even in the most favourable cases led to ulceration in the neighbourhood.

A greater part of the indications for intravenous treatment disappeared with the introduction of the Pravaz syringe (1853), which rendered possible the simple subcutaneous injection of medicines, instead of a complicated operation that could only be performed by an expert. In this way intravenous treatment gradually fell away into forgetfulness, and for decenniums it was scarcely ever practised, until the animal experiments of Kronecker and Sander, who saved dogs from certain bleeding to death by intravenous injection of physiological saline solution, which prompted Landerer to try this method of treatment, not only in cases of acute anæmia, but to give other medicines by way of intravenous injection.

There may be a divided opinion regarding Landerer's (1895) so hardily contested intravenous injection of hetol, but the services of that inquirer are incontestable in restoring the endovenous application of remedies that were well-nigh forgotten, and making

the common property of the profession.

Considerable impulse and vitality was given to intravenous treatment by Baccelli, especially by his works on the intravenous administration of quinine and sublimate, which gave an impetus to a new and brilliant development of this method of treatment. In 1907 Crede introduced intravenous silver treatment by collargol. In the same year Herxheimer introduced the intravenous injection of arsenious acid, which ranks along with the intravenous injection of sodium cacodylate introduced by myself in 1902-3 An iron combination with cacodylic acid (ferricodyle) has been given by venous injection in place of the internal administration of Franck (1966). As, however, sodium caco-dylate, in consequence of its ready decomposition, seemed less suited for intravenous injection than a new organic preparation of arsenic, atoxyl, in carrying out intravenous arsenical treatment I have given preference to it. As early as 1901 Robert Koch had ascertained by experiments on the human subject that tubercle bacilli (and especially T.O.) had the property, even in small doses, of raising the agglutinating power of human serum against tubercle bacilli to a surprising degree, and that they showed themselves active even when no effect was produced by subcutoneous injection, although the dose was increased. This observation of Koch's justified the certain expec-tation that the "alttuberculin" also injected direct into the vein would exert a considerably more powerful bactericide action. For this reason the intravenous injection of "alttuberculin" alone and in combination with atoxyl was recommended by me, and by this the impulse was given for the employment of other bacterial products for the purpose of accelerating or increasing their action, as proposed by Lehmann (1904) with regard to the intravenous injection of Behring's curative serum in bad cases of diphtheria.

In 1904 the intravenous injection of salicylic acid was introduced by me, and simultaneously with this specific remedy, caffeine, which opened the way for the alkaloids, which are specially suitable for intravenous injection, and, even as long as ten years ago, were many times introduced directly into the blood

current (morphia, strychnine, etc.).

With the intravenous injection of caffeine, introduced by me (caffeine sod. sal. 1:10), which gave us the power of at once increasing the power of the heart from the blood current, properly begins a series of important experiments to prepare remedies for the heart, and especially digitalis for intravenous injection. This must appear the more important, as this indispensable and active cardiac stimulant frequently offers the greatest difficulties, both as regards internal and subcutaneous administration, and its action, as at present incorporated, is too slow to afford relief in time when the indication for it is a vital one. In 1905 Kottmann introduced digitoxinum solubile Cloetta (digalen) into intravenous therapeutics, and simultaneously and independently of these investigations digitalonea digitalis dialysate, a preparation of the firm of Parke, Davis, and Co., was recommended by me for intravenous medication. After the attempt of myself and Kottmann to introduce cardiac remedies by way of intravenous injection had once been successfully made, Fraenkel, from his intimate knowledge of the digitalis bodies, ventured to introduce direct into the venous blood channel a much more rapidly and even heroically acting remedy of this group-strophanthin (Böhringer), a remedy that Baccelli had made use of independently of Fraenkel in paroxysmal tachycardia with a brilliant effect.

Ample experience has shown that intravenous digitalis treatment, whether caffein, digalen, digitalone, or strophanthin, be made use of, is an important advance

in the treatment of cardiac cases.

Adrenalin-saline solution, first recommended by Heidenhain, which often has a life-saving effect in diminished intraperitoneal blood pressure, serves a similar purpose.

In recognising that the treatment of infectious diseases must form the real domain of intravenous therapeutics, and as atoxyl has been recognised as a specific against the so-called protozoa diseases, I pleaded urgently for its employment both in sleeping sickness and in malaria. Von Döevenspeck has recommended the intravenous employment of potassic iodide in bad cases of syphilis, whilst the intravenous injection of quinine of Lehmann may be mentioned as the most recent achievement in this direction.

Even if the injection of potassic iodide and colchicin iodide, with attendant success, has up to the present gained no practical importance, and the intravenous infusion of oxygen has, so far as I know, only been employed in the case of animals, we see from the above that the most important remedies are eminently suited for intravenous injection free from all disturbing by-effects, and develop their curative action in a prominent manner. From our present experience we may make the formal pronouncement that intravenous therapeutics, with a suitable selection of remedies, and skilfully carried out, is free from any local or general injury to the patient.

If, in spite of this, intravenous treatment has remained a terra incognita, full of terror, and one that the ordinary practitioner dare not venture upon, is due to the fact that, up to quite recently, there was no klinik in which this mode of administering remedies was taught, and because University circles especially held aloof from this form of treatment. On the other hand, I have often seen that medical men who have had the opportunity of seeing the simplicity of the proceeding themselves, and the brilliant results of the picceding themselves, and in ordinal testing following it, have become enthusiastic admirers.

The technique of intravenous injection is exceedingly

simple, and may be carried out easily and without danger, as well in the consulting-room as at the bedside. Although during the course of years proposals of improvements have been made by various authors, both in regard to the instrumentarium and the technique, I have found no occasion to deviate from that first described, and fully tested except in one particular.

The apparatus that the firm of J. and H. Lieberg, of Cassel, made from my instructions, and supplied in a very handy case, consists of a band of black indiarubber 6 cm. in width and about 1 metre in length, and a Lieberg 2 gm. syringe, with a not too fine platinum-iridium needle. In the Lieberg case are two needles in a metallic cover, in which they can at the same time be sterilised. There is also in the case an ether bottle with an ingenious stopper, and room for the ampullæ, with the medicines.

After the cannula has been boiled in water, and the needle which is to be used has been washed, and some of the same water passed through, it is filled with the medicine, the needle fixed firmly, and the air driven out of both syringe and needle. The veins at the flexure of the elbow are then closed by the elastic ligature, and the point of puncture rubbed with sulphuric

That vein is to be selected for puncture that ether. seems to the touch to be the most tense and adherent to the skin, so that the needle, on entering, cannot slip aside. Then the cannula, firmly fixed on the syringe, is passed straight in, and when we see the column of blood mounting in the cannula and syringe, forced there by the strong pressure on the contents of the vein, and are assured thereby that the cannula is really in the lumen of the vein, or when we have satisfied ourselves that it is by drawing slightly on the piston, slowly and under equable pressure the contents of the syringe are passed into the vein. After the cannula has been withdrawn, and a pledget of gauze placed on the site of the puncture, the bandage is taken off. Many loosen the ligature, or allow the patient to do so, before emptying the syringe, as soon as the cannula has entered the lumen of the vein. This method has the advantage that the medicine at once pours into the open channel of the vein, and in this way any lengthened contact of the drug with the wall of the vein is avoided. We must act in this way when large quantities of fluid are to be injected at once. It has, however, the disadvantage of uncertainty, as, after loosing the ligature, the needle may easily get displaced by movements of

By my method I have often made 50 and more injections in the same spot of the same vein, without being able to detect the slightest trace of irritation or thrombus. For any damage to the intima of the vein and the formation of thrombus due to it, the character of the fluid injected is responsible. It is injurious to the vein and disagreeable to the patient when some of the fluid to be injected, instead of going into the vein, gets into the perivenous tissue, as it is the property of most intravenous medicaments to set up painful inflammations and infiltrations, and as a consequence of these venous thromboses it is advisable to carry out intravenous injections only with medicines which are sterilised in individual doses, and preserved in ampullæ, with their necks closed by melting of the glass, and in this way be sure that the material is free from germs and decomposition. Such ampullæ are mostly prepared in the factories and kept in stock in drug vendors' shops.

With the extensive range of employment of intravenous medication, and its great activity in numerous cases of illness, it seems proper to discuss the methods of treatment that are of the greatest practical import ance, their indications, as well as the exact mode of action and dosage of the materials to be employed.

(1) Treatment by Hetol (Landerer).

After Landerer had recognised Peruvian balsam and its derivatives, and especially cinnamomic acid, as excellent anti-tuberculous external applications, he attempted their employment in internal tuberculosis, first the balsam of Peru and the cinnamomic acid. As, however, the intravenous use of these preparations proved to be harmless only with the greatest caution, and in most cases were followed by injurious byeffects, the general employment of this treatment only became possible when, in place of cinnamomic acid, a 1 to 6 per cent. aqueous solution of cinnamomate of soda (hetol) was introduced by Landerer, as an intravenous injection in the treatment of tuberculosis. This remedy, just like cinnamomic acid, is said to form an inflammatory wall, consisting of round cells, a pneumonia-like process, round the tubercles, which have but little tendency to cicatrise. From the round cells of this inflammatory area a growth of connective tissue takes place through the diseased centre, causing gradual contraction of it, healing, and cicatrisation. Most authors have been able to determine that a strong lymphocytosis takes place, which is looked upon by Landerer as an important curative factor in the treatment of tuberculosis.

The method of treatment by hetol is the following:— The cinnamomic treatment should begin with the smallest doses (1 mgm. of hetol), and this can be gradually raised to the average dose proper to each case, but 25 mgm. must be considered the maximum dose.

Hetol treatment should set up no increase of fever, neither should it in any way be injurious to the general condition; in case it does, the dose must be reduced, or the treatment stopped altogether. Generally speak-

ing, one should try to get along with the smallest possible doses, and to be especially careful of the dosage when there is a tendency to hæmorrhage. The duration of the period of treatment varies from thirty days to three months.

In Landerer's opinion, we have in cinnamomic acid and its derivatives a remedy that has a powerful influence in tuberculosis, the intravenous injection of which is absolutely harmless, and which, in a considerable proportion of those suffering from internal tuberculosis, and especially in cases without fever, and free from considerable disturbances, will bring about absolute or comparative recovery in the course of a few months.

This treatment, inaugurated by Landerer, has been tested a good deal quite recently. All authors are agreed on one point—that the treatment does no harm, whilst favourable reports on the success of the method are opposed by a number of others, which make this success questionable, and, judging from the most recent experiments on animals, no action on tuberculosis can be ascribed to it.

(2) Intravenous Treatment by Silver (Credé).

Credé attempted to make use of the highly antiseptic properties of silver by introducing it in a soluble form, in which it caused no precipitation in the blood fluids, and only passed away from the blood-vessels very slowly. Collargol (argentum colloidale) is supposed to possess such properties, and, for this reason, to be peculiarly suited for introducing into the blood, and the whole body, a solution of silver.

The intravenous injection of 1 to 5 ccm. of a 5 per cent. solution is acknowledged by all authors to be quite harmless. It is borne by the walls of the veins without any irritation, as there is no local reaction, and the dose may be repeated in 24 hours. Along with the percutaneous incorporation of collargol by means Credé's ointment, he recommends intravenous injection, especially in cases in which a prompt effect is desirable, or where from any cause-disease of the skin, cachexia, or age—there is not likely to be suffi-cient absorption through the cutaneous tissues, in all cases of septic infection of any kind, and whatever the cause may have been. In the whole of the cases even in those that appeared hopeless by any other method of treatment-rapid improvement is said to have set in, even in a few hours' time, as shown by improvement of the general condition, rapid fall of fever, and retrogression of the septic process. An extensive list of cases goes to show the great value of this form of treatment through the whole domain of septic infections (sepsis, pyæmia, erysipelas, angina, diphtheria, pneumonia, febrile tuberculosis, gonorrhœal articular diseases, etc.). Opposed to this is a series of writers who, as well by experiments on animals as by their own experiences at the bedside, seek to prove that collargol is not only absolutely inactive, but must be so from the slight bactericide power of the material injected.

The question of the value of collargol treatment is therefore uncertain at present, and it will require a long time to accumulate a sufficient number of observations to decide the question of its value. In my own opinion this is the more difficult, as the septic diseases run so varying a course, and even in their severest forms not unfrequently may take such spontaneous sudden turns for the better that it must often seem impossible to weigh the post hoc and the propter hoc against each other with any degree of certainty.

(3) Intravenous Arsenical Treatment (F. Mendel).

(3) Intravenous Arsenical Treatment (F. Mendel). As the disagreeable by-effects of this old and well-tried remedy have stood in the way of its employment in sufficiently large doses and for sufficiently long periods, pharmacologists have for a long time been seeking for a substitute for arsenious acid which, without injuring the gastro-intestinal canal and causing various symptoms of intoxication, may be given for lengthened periods and in efficient doses. As such a preparation of arsenic atoxyl was introduced into therapeutical use by Schild and Blumenthal in the year 1902, and its intravenous injection in 20 per cent-solution was recommended.

From its employment in a large number of cases I have given the preference to a 15 per cent. solution, in order by this means to get not only a more efficient

smallest trace of the treatment.

ORIGINAL PAPERS.

THE MEDICAL INSPECTION OF SCHOOL CHILDREN.

By H. O. PILKINGTON, M.D., D.P.H.,

Medical Officer of Health for Preston.

Treatment by intravenous injection of atoxyl is begun by one-third of a gramme of a 15 per cent. solution of atoxyl, gradually increasing the dose to 2 gm.equal to 0.3, which I consider as the maximum dose. The injection is repeated every second day generally for four weeks, then twice a week, then once a week, to the end of the course. Atoxyl is used in all the ciseases in which arsenic appears to be indicated. The results, from the absence of by-effects and the relative harmlessness of the preparation, may be said to be brilliant in comparison with the preparations hitherto

action, but also absolute paintessness of application. For subcutaneous injection, in spite of the most careful asepsis, it not infrequently causes considerable irritation far beyond the site of the injection, whilst a

15 per cent. solution poured into the vein is so non-

irritant that 50 injections and more may be made at the same spot in the vein, without leaving behind the

This method of arsenical treatment proved itself very effective in the most diverse disturbances of blood formation (chlorosis, anæmia, leukæmia), in nerve diseases of the most varied kinds (neurasthenia, hysteria, nervous asthma, paralyses, neuritis, chorea, etc.); also in Basedow's disease, diseases of the skin, glandular swellings, pseudo-leukæmia

The intravenous employment of atoxyl in tuberculosis deserves special notice, as it is just in this disease, associated as it is with loss of general power, that it shows most clearly the favourable influence that arsenic in this form has over the general processes of nutrition. It is in tuberculosis that atoxyl proves itself to be an excellent remedy for raising the lowered vitality of the cells and increasing their power of resistance against the tuberculous poison.

Atoxvl has gained distinguished importance in the treatment of tuberculosis, but it did so first through my introduction of the intravenous employment of atoxyl and tuberculin for that disease, which, as I should like to mention, showed the best results in the out-patient treatment of the first and second stages of the disease. In this combined arsenic-tuberculin treatment, the procedure is so that to the increasing dose of the arsenic, if the case calls for it, an increasing dose of tuberculin is added in such a way that the syringe containing the arsenic is made to take up so many parts of a 1 to 1,000 solution of tuberculin as will make an injection of a decimilligramme of tuberculin.

By the intravenous injection of these two substances, a bacterial product and a chemical substance, we first of all succeed in multiplying many times over the specific action of the tuberculin, as shown by Koch's experiments. At the same time, an inflammatory hyperæmic zone is formed around the tuberculous centre from the local reaction of the tuberculin, the result of which is the formation of a reserve of the arsenic circulating in the blood, and with it an increased curative effect in the cell territories that are the most endangered.

The tuberculin thus forms, to make use of Ehrlich's expression, the loaded waggon, carrying the burden entrusted to it—the arsenic; passes it on to the parts most in danger; at the same time it develops within the organism in a high degree a protective power against the virus of the tubercle, whilst the arsenic, along with its increased local curative effect on the diseased parts, exercises a general tonic effect. combined arsenic-tuberculin treatment, fulfils all the requirements which Ehrlich has called for in the ideal remedy, as it allows the various factors to come into action, the coming together of which first renders a curative effect possible—(1) the distributive constituent parts regulating the dissemination (tuber-culin); (2) the pharmacophore group (as + tuberculin), rendering a specific action possible.

NOTE.—A Clinical Lecture by a well-known teacher eppears in each number of this journal. The lecture for next week will be by Felix Mendel, M.D., Essen (Ruhr.). Subject: "The Present Position of Intravenous Treatment." -Part II.

By Section 13 of the Education (Administrative Provisions) Act, 1907, a duty is cast upon a Local Educa-tion Authority of providing for the medical inspection of all children entering a public elementary school, such inspection to be made immediately before, at the time of, or as soon as possible after, the admission of each child.

In addition, an inspection shall be made of each child on such other occasions during its school life as the Board of Education may direct, and the present direction is that the inspection upon admission shall be followed by another about the third year of school life, and again by another about the sixth year. recommended that a still further inspection shall be made when the child leaves school and commences some form of employment, and in some districts it is considered possible that this final examination may with advantage take the place of the third, that in the sixth year of school life. This Act came into force in January of the present year, but it was quite recognised that such an important undertaking could not be got into steady, regular working order without a great deal of preliminary trouble and careful consideration, and therefore it is not expected that a Local Authority can do much more than examine the entries made during the first year.

A recent Memorandum explains that the Board will be satisfied, so far as the present year is concerned, by the inspection of all children entering after August 1st, and those who are likely to leave before

or about July, 1909.

The Board recognise that such an important work as this cannot be commenced, and certainly cannot be got into smooth working order, without a good deal of discussion, of preliminary trial, and of

gradually acquired experience.

Undoubtedly, this Act requiring the medical examination of school children is one of the most important, and, it is to be hoped, will prove one of the most beneficial, of recent years. It is the outcome of a feeling that amongst the children now growing up there is, if not an actual physical degeneration, at any rate a falling-off from the standard which might naturally be expected.

There is already evidence—and this will be confirmed by the inspections now going on—that many children are suffering from ailments, and from physical disabilities, which are either altogether unrecognised, or else are treated as matters of no importance, or as conditions which time may cure, and which must be left to chance, good fortune, or Providence. In this way men and women have grown up, and are now suffering from defects which, if only recognised and judiciously treated during their school-going age, might have been materially relieved, if not altogether cured. Every child, and more especially children of the working classes, enters upon the struggle of life heavily handicapped if it has not full possession and use of all its limbs, senses and faculties.

Few people fully appreciate the heritage of a sound constitution, and the blessing of having a fair start in that race in which the cripple must needs lag behind; a fair chance in that struggle in which the weakest must almost invariably go to the wall.

is the object of a medical inspection This, then, of school children—to detect abnormal conditions whilst still they may be improved, weak spots, which now, perhaps, of little importance, may, if left untreated, develop into serious ailments, and conditions which may perhaps have no very serious influence on the health of the child, but which indicate negligence and want of proper care on the part of parents and guardians.

It is evident that the medical inspection of a child is intended to be the means of detecting some unnatural condition, and is but the first step-but an absolutely necessary one—towards its amelioration or cure.

Since this inspection of children is but another form of Public Health work, it has been decided that it must come under the supervision and control of the Health Officer for borough, township, district, etc.

The course adopted in Preston may be taken as a

The course adopted in Preston may be taken as a type of that which has been carried out in most of the large towns. The Medical Officer of Health is supervising officer, but since it is evident that his other multifarious duties will prevent his acting as actual inspecting officer, a fully qualified medical man has been appointed, upon whom will devolve the actual and responsible work of inspection. But, in order that this work of inspection may be carried out in the most efficient, and, so far as time is concerned, in the most efficient, and, so far as time is concerned, in the most efficient, and, so far as time is concerned, in the most efficient, and, so far as time is concerned, in the most efficient, and to operation of the teachers should also be obtained. It is of primary importance that they, who have so much to do with the well-being of the school and of the school children, should take an interest in the work, should see that it is intended to benefit the children under their care, and that the increased labour which may and will be thrown upon their hands is likely to bear good fruit in the improved health, and future happiness and success of the children over whom they are placed in charge.

This interest once aroused, this co-operation once secured, much of the difficulty which must surround the inception and inauguration of an important measure like this, is at once overcome.

For some years past in Preston, as in many other large towns, there has been a relationship between the Education and Public Health Departments, working for the good of the school children. All cases of minor infectious disease—those not compulsorily notifiable under the Infectious Diseases Notification Act—as, for instance, measles, whooping-cough, mumps, chicken-pox, ringworm, and various skin eruptions, occurring amongst the children of a school, are reported to the Health Office by the teacher.

These cases are attended to by the Health Visitors, who give advice (carefully avoiding any opinion if a medical man be in attendance), upon the need for isolation, and see that the proper period of quarantine is observed. In the same way, the Health Office supplies the teachers with information of those houses in which cases of the more serious forms of infectious disease are reported to have occurred, and so enables them to prevent children from these infected houses attending school until the period of danger has passed and the house and contents have been disinfected.

It is here that, under the present Education Act, the services of Health Visitors may be further utilised. The Medical Inspector of School Children cannot himself visit them at home, or see that the advice which he may give is properly carried out.

Such a course might bring him into conflict with the private practitioner, the medical adviser of the family, and this is a point which by all means must be avoided. But notice of suitable cases sent to the Health Office will ensure the services of the Health Visitor, and the Education Authority recognise the importance, and, indeed, the necessity, of the co-operation of school nurses, or Health Visitors, who will serve as a connecting link between the school and home, will secure and maintain the personal cleanliness of the child, will see that medical advice is obtained in necessary cases, and stimulate the parents into a proper sense of their responsibilities.

Besides the actual detection of disease, want of cleanliness, etc., the Medical Inspector will be able to pick out those children who are either mentally defective, or who, on account of physical ailments, are unfitted to take their places amongst children of their own age, and for these he can suggest some modification of the system of education suited to the needs and capacities of such children. Children with pronounced deficiency of intellect, (idiots and low-grade imbeciles) should, of course, be withdrawn from an ordinary school. They are subversive of discipline, and to a certain extent are infective, since they spread demoralisation around them, and impede the educational advancement of the other children. For them treatment in some special institution is impera-

tive. But those who are defective in a minor degree, the simply backward children, should not be withdrawn from the general system of the school, or from contact with the other children, but should be subjected to some modified form of education, which will strengthen their weak points, and draw out—educate—what they have of the best. This is the opinion of Sir James Crichton-Browne, expressed very much in the words which he used when speaking on this subject at the recent annual dinner of the Society of Medical Officers of Health.

Now as to the actual manner in which the inspection of these school children is to be carried out.

It is required to be held on school premises and during the recognised hours of school work.

In making the necessary arrangements, the circumstances of the school must be taken into consideration, and also the convenience of the teaching staff, so that the routine work of the school may be as little as possible interfered with. If possible, a separate room should be obtained, so that the general body of scholars are not distracted from their lessons.

Certain apparatus and instruments are necessary, some being required in the case of every child examined, others only in those cases in which some defect is apparent, but all these are intended simply for examination, and not for curative purposes, these latter being outside the medical examiner's functions.

The particulars of the examination are first set down upon a card, ruled so as to show the various particulars during each of the four examinations required by the Act. First comes the child's name, date of birth, its address, and name of school which it is attending. Then its previous history, so far as to show any serious illness which is likely to have any effect upon its future health, also the family medical history, if there be anything exceptional to record. These are general items, which once recorded, need not again be dealt with. Then follow the personal conditions, as found on each inspection, divided under 24 headings. Date of inspection, standard and regularity of attendance, age, condition of clothing and foot-gear, height, weight (these may be taken in English measures, but in Annual Report averages must be given in English and metric systems), nutrition, cleanliness of skin, head, and body, and condition of teeth, nose and throat, tonsils, adenoids, glands, eye disease, vision R. and L., ear disease and hearing, speech, mental conditions, heart and circulation, lungs, nervous system, tuberculosis, rickets, deformities, spinal disease, infectious and contagious disease, other disease or defect, general observations. Then follow any directions which it may be necessary to give to the parent or teacher, for their guidance in dealing with any defect which may have been discovered. All the facts relating to the child are recorded on the card bearing its name, and are afterwards copied in a register, to be regarded as confidential and to be kept at the school. The cards are kept in cabinets, one for each school, and should the child remove to another school, the card will accompany it. The presence of the parent at the first examination is recommended, at any rate, the opportunity of being present should be afforded.

Now, it will be seen that this examination is a very

Now, it will be seen that this examination is a very comprehensive one, and covers a great deal of ground; at any rate, it covers the whole of the child's body.

If the assistance of the teachers can be obtained, a good deal of the first part can be done by them; the height and weight can be taken, the family history ascertained, the attendance recorded, etc., and the child can be prepared—as to its dress—for the doctor. The memorandum issued by the Board of Education states that—"The examination of each child need not, as a rule, occupy more than a few minutes." But it would be very difficult in a few minutes, under the most favourable circumstances, to examine into, and then record, all the particulars dealt with. The examination of the vision by means of Snellen's Test Types, at a distance of 20 ft. or 6 metres, alone takes up some little time. Of course, there will be a certain proportion of children, obviously normal and healthy, whose examination will occupy comparatively little time, and they will serve to leaven the lot, and re-

duce the average amount of time required. Children who give evidence of some abnormal condition, impaired hearing or sight, spinal weakness or curvature, adenoids or other nasal obstruction, diseases of respiration, of circulation, etc., will be marked out for a further and more searching examination, probably carried out in the medical department of the School Attendance Offices.

In this way few children, who are in any way ailing or defective, will escape observation, but the after treatment presents greater difficulties, or rather the very necessity for it shows how far the Act may be extended, and that in numerous instances the inspection of the child is but the preliminary step, and will have to be followed, where necessary, by treatment at the public expense. It is obviously absurd to point out that a child is suffering from spinal weakness, or defective vision, if the parents are too poor or too apathetic to obtain the necessary treatment. Take the case of the teeth alone, which in the majority of the children are in a more or less decayed and carious condition. If not properly dealt with, they can only go from bad to worse, their condition being more than likely to exercise a baneful influence over the child's general health and development. And yet, amongst the labouring classes the teeth go through life untended and untouched, except when recourse is had to extraction to terminate the pain of an aching tooth, which, very possibly with proper attention, might still have been preserved.

extraction to terminate the pain of an aching tooth, which, very possibly with proper attention, might still have been preserved.

In seasons of prosperity and good trade, the difficulty will not be so great, but given a time of depression, of shortness of work, and scanty wages, and it will be found that the inspection of the child is but the first step towards providing for it. It would be little use recording that a child is insufficiently fed, imperfectly shod, and without sufficient clothing to keep it fairly warm, if it is known that these conditions, although fully recognised, cannot be relieved at home. There are, of course, many charities, and charitable institutions, and possibly arrangements may be made by which the requisite assistance, may wholly, or in part be obtained for those children whose parents are themselves unable to defray the cost. But these are matters which will have to be dealt with in the future, and the Act as yet has not been sufficiently long in operation to enable us to say how great will be the difficulties, or how best they may be avoided or overcome.

Instruction in the principles of hygiene, which teachers and intended teachers are now receiving, and which will be conveyed by them to the children under their charge, will do much to remove such evils as those arising from absolute ignorance of the structure and functions of the skin and teeth, and the consequent want of care in their treatment and preservation. The use of baths and tooth brushes, now forming in most schools a part of the curriculum, will not only be of direct and immediate benefit, but will also have an improving—a civilising—tendency; and will bring home to the rising generation the good effects resulting from personal hygiene.

Now, to the already sufficiently burthened rate-payer all this may seem but another step towards relieving a certain class of parents of the responsibilities which—as parents—must, and should, remain with them for the maintenance and up-bringing of their offspring. By some it will be said that all that such a parent need do is to produce the child, and the State will nurse it, vaccinate it, wash it, educate it, and, if necessary, feed and clothe it. It is, however, stated in the Memorandum issued by the Central Education Authority that "one of the objects of the new legislation is to stimulate a sense of duty in matters affecting health in the homes of the people, to enlist the best services and interest of the parents, and to educate their sense of responsibility for the personal hygiene of their children. The increased work undertaken by the State for the individual will mean that the parents have not to do less for themselves and their children, but more."

It is to be hoped that the parents in question will see matters in their proper light, and will, at any rate, exert themselves to co-operate with the Education and Health Authorities in their earnest endeavours to protect the health and improve the general condition of the poorer class of children in the town.

### BOOTS, AND THE TREATMENT OF CORNS AND PLANTAR WARTS. (a)

BY ALFRED EDDOWES, M.D.EDIN.

MR. PRESIDENT AND GENTLEMEN,—My attention was directed to this subject by a bad case of plantar warts which came under my care, and forcibly emphasised the practical importance of the malady. The patient, a young lady, had suffered some pain and inconvenience on the sole of the foot for two years; latterly all games had to be given up, walking was painful, and there was sometimes pain even in bed. A large number of such cases are going about constantly suffering, and are merely relieved a little now and then by chiropodists. The cases are essentially surgical, often easily curable in a week, may last a lifetime untreated, and are well worthy of careful study by those who are not already familiar with them. So much by way of introduction.

It must be understood that I shall make no attempt to deal with such a wide subject in a systematic and comprehensive way. I will merely enumerate some of the most important troubles which the feet are liable to, mainly from boots, and suggest means to lessen or remove them.

Blisters.—These usually occur on the instep, heel, sides and soles of the feet. Friction on the instep is usually caused by a badly-cut boot. A well-cut boot should have the line of lacing so cut that the front is smoothest and most closely adapted to the shape of the foot when we stand up. In this way the freest movement is allowed without unduly wrinkling the leather during extension or dorsi-flexion.

Blisters on the heels are usually caused by a boot slipping up and down with each step because the uppers are badly cut and do not take hold of the back of the heel. In other words, the line of the back part of the boot is too upright and straight, and does not recognise that the heel is more prominent than the tendo-Achillis. On the sole of the foot blisters are most commonly caused by roughness of the bed of the boot. Those forming at the side of the feet may be very extensive, and result from the sharply-bevelled edge of the bed of the boot, especially if the bed be too narrow.

Inflamed Nail-bed and Matrix.—The common causes of these very troublesome affections which bring about excessive thickness of nail-growth, if not actual deformity of the nail, are too short boots. with too little space in the toe of the boot, the last having been too short and too chisel-shaped. The result is well shown in an exaggerated form in the photograph I now pass round. There you will see about fifteen to twenty years' growth of the big toe nails both of which are turned upwards and backwards, and twisted like small rams' horns. These affections may have their origin in one definite injury, but more commonly they are due to wearing of too short boots, neglecting to cut the toe-nails, or from want of space in the toe or toe-cap of the boot, as has just been said. Most lasts make no allowance for the greater size of the big toe, so the roof of the vamp is not high enough.

In-grown Toe-nail.—This condition is at least greatly aggravated by short boots with too little space in the vamp, and too narrow a boot.

Bunion.—Bunion was much more common years ago when boots were more pointed in the toes and

<sup>(</sup>a) Read before the Chelsea Clinical Society, Feb. 16th, 1909.

spindle-shaped, that is to say, the line from heel to great toe was curved too soon and drove the big toe towards the centre of the foot.

Hammer-toc.-When this is acquired, as I believe is the rule, it is due to too narrow and too short

Flat-foot.-The ordinary flat-foot is greatly aggravated by the wearing of boots which are too unvielding, especially in the waist. Lacing firmly tends to drive the arch of the foot downwards upon the sole as if it were a ridged splint, and the extra strain thrown upon the arch of the foot tends, especially in cold weather, to excite severe cramps -generally coming on after getting into bed.

Morton's Disease, or transverse flat-foot, is an extremely painful malady when fully developed. It is, in my opinion, due largely to the cramping of the heads of the metatarsal bones in tight boots and boots which have too thin or too soft soles, which sometimes, when wet, will bulge downwards and encourage a corresponding bulging or descent of the heads of the second, third, or even the fourth

metatarsal bones.

Corns.-As we all know, corns are caused by over-stimulation of certain points on the foot through friction or intermittent pressure.

Warts of the feet may occur at any part, but it is only when they occur on the plantar surface that they are at all difficult to diagnose. They can be frequently distinctly traced to injury, plus, no doubt, various forms of infection.

Simple or infected wounds are of frequent occurrence owing to the scratching of the soles of the feet by badly-clinched nails or projecting wire sutures. I have known bits of wooden pegs, unremoved by the shoemaker, cause wounds.

SANDALS.

No one who realises that a boot can, and should be, so cut and formed as not to injure the feet would ever dream of recommending sandals for children, especially in our towns, where there is constant danger of infection of various kinds which

I need not specify.

Celluloid Heels .- Not satisfied with making dangerous inflammable combs, from which I have already seen terrible disasters, manufacturers, I am informed, now produce celluloid heels. Can any more horrible accident be imagined than might occur to a young lady coming home from a ball in an inflammable dress putting her feet near the fire, then suddenly finding the heel of her shoe blazing out into perhaps a cubic yard of flame, the result inevitably being death sooner or later, or a crippled condition for life. The result is too horrible to contemplate. The use of celluloid and other substances of such inflammable nature should be at once forbidden to form any part of boots, at least.

BOOTS. Having considered the chief faults of boots, let us see if we cannot lay down some definite and useful rules about the shape and make of a good boot. It should be easy, particularly for a soldier, to get his boots off and on quickly; therefore, in laced boots the opening should be as far down as the widest part of the foot, that is, a line running from the big joint of the great toe to the base of the little toc. The uppers should be so cut as to be smooth when the boot is laced and the wearer stands up in it. The back of the heel of a boot should receive the heel comfortably, and be so shaped as to prevent the foot working up and down during walking. There should be a little extra space about half an inch deep provided for by the shaping of the last-a little space which would correspond in position to that of a skirting-board

in a room-to prevent any cramping of the heel when it expands slightly backwards and outwards when pressed upon. If the space is not allowed, every step must fend to thrust the foot a little bit forward in the boot during every step. The bed of a boot, upon which usually lies a thin permanent leather sock, should be slightly cupped at the heel, slightly raised on the inner side for the arch of the foot, and the whole should be so wide as never to allow the flesh of the foot to be rubbed by overlapping its bevelled edge. All nails, wire stitches and wooden pegs should be carefully dealt with or removed. In light boots especially the waist should be sufficiently flexible to come up if necessary, and not force the foot down when the boot is laced. The vamp or whole front of the boot, if not soft, should be roomy enough to just hold the foot com-fortably when raised from the ground, and the toe or toe-cap should be high and wide enough to prevent the toes being cramped or the toe-nails pressed upon in any direction.

The Sole.—Given a sole of sufficient thickness and strength, we now come to one of the most important points in the whole of boot constructioni.e, the cut or shape of the sole. If we look at the foot, we see that the two large toes are as wide as the three smaller ones. If we take a base line running between the second and third toe to the centre of the heel, we shall find that it becomes a very simple matter to lay down definite rules as tothe shape that the sole of an ordinary boot should assume. If at the widest part of the foot we draw a cross line and make it of equal length on each side, this runs from the great toe joint to the little toe. If we divide the length of the foot into fifths we shall see that both the inside and the outside of the sole of the boot should be practically straight until the little toe is reached, or practically fourfifths of its total length. Years ago boots were too pointed, consequently the big toe was driven out-In order to obviate this, it was taught wards. that a boot should be straight on the inside from the heel to the point of the big toe, and in order to carry this view out, lasts were straightened on the inside without any due regard being paid to injury inflicted on the outer part of the foot (especially the little toes) by the outer side being curved too much and too soon, and made to resemble the convex border of a kidney or a boome-The last should have had something taken rang. away from it at the proper spot, and that something added to the outside at the proper spot. And so the boot could have been easily built on proper lines. Many of the old faults are being removed, and it is now possible to buy extremely comfortable readymade boots; but there is one fault still remaining which I have been unable to induce any shoemaker so far to give up. He seems unable to realise that the heel should not be set on in the line of the waist of the boot, but in relation to the base line of the foot itself. If the heels of our boots were turned, the right one a little outwards at the back and the left one correspondingly, we should then not tread the heels of our boots down in the way we do at present. I will illustrate these points by the diagrams I have brought with me. CORNS AND WARTS.

Now for a few words on the treatment of these troubles. As far as possible, of course, any known imperfections in boots likely to aggravate these conditions should be removed. Any corn can be rapidly cut down by a suitable file, and filing is a There is an far safer proceeding than cutting. cellent file in the market known as the Alexandra corn rubber, made apparently of dog-fish skin. It cuts a corn rapidly away, and if it becomes clogged it can be easily cleaned by a bit of cotton wood dipped in methylated spirit. Occasionally when a corn has been rubbed down the skin at the spot is still tender when the boot is worn. To meet this, more room can often be afforded, and therefore less pressure felt by wearing a thinner stocking for a time; or a corn plaster can be worn, or, better still very often, a strip of ordinary plaster above and below. Another simple expedient is to wet the boot just over the corn with very hot water, giving the water time to soak well in, and then wearing the boot all day so as to block the leather to the shape of the corn. The part of the boot so treated should be wetted with castor oil at night, as that will ensure that the leather does not set hard.

Plantar Warts.—It often requires a practised eye to recognise the presence of warts in the thick skin of the sole of the feet, because they usually form a part of a rather extensive callosity. Sometimes in such a callosity the warts are disseminated, and we only discover them by cutting away the hard substance until we expose little black dots or breeding points of still living papillary loops. Occasionally we find them complicating the painful condition known as Morton's disease. When they are disseminated, my practice is to cut them down until one can see their full extent, then to apply fuming nitric acid to every one of the spots which one can recognise as being warty. It is well to tell the patient that it may have to be done again, because you cannot be sure that the whole will be at once destroyed. After the nitric acid has had time to act, the excess is wiped off and a thin pad strapped on; patients can often go about during the treatment. Occasionally one or more of the points will become inflamed and suppurate. The patient should be told that this may happen, and that if it does he has only to come to you; the corn can easily be removed and the pain relieved, and then it requires only a short time and appropriate dressing to complete the cure. Sometimes the wart can be scooped out as a well-defined sodden little mass, either under gas or after a local anæsthetic has been administered. It cannot be too definitely stated that it is quite useless attempting to cure such plantar warts by the ordinary methods of chiropody for corns. If not treated they may last a lifetime and cause great suffering. If carelessly cut they may lead to serious, and even fatal, blood-poisoning. The simple corn can be simply treated, but the wart, and mixed condition of wart and corn, require skilful modern surgery.

THE SPIRILLUM OF VINCENT IN CERTAIN

## PATHOLOGICAL CONDITIONS OF THE MOUTH AND THROAT. (a)

By MILES B. ARNOLD, M.D., D.P.H.,

Assistant Medical Officer of Heal h to the County Borough of Blackburn.

I was led to the consideration of the organisms, described by Professor Vincent, when I was comparing films made direct from all the forms of throat infection that were at my disposal. I was surprised at the numbers of spirilla which could be seen on careful examination of films, and later on looking for them, I also saw fairly frequently fusiform bacilli.

The results of these examinations were as follows:—

In 15 cases of diphtheria, 4 showed spirilla or spirilla and fusiform bacilli.

In 20 cases of septic scarlatina, 7 showed spirilla, or spirilla with fusiform bacilli.

In 4 cases of post-scarlatinal (non-diphtheritic) infection, 2 showed spirilla, or spirilla and fusiform bacilli.

In 5 cases of follicular tonsillitis, 3 showed spirilla, or spirilla and fusiform bacilli.

In 3 cases of exudate from tonsillar crypts (non-inflammatory), 3 showed spirilla, or spirilla and fusiform bacilli.

In 5 cases of membrane forming after tonsillotomy, 2 showed spirilla, or spirilla and fusiform bacilli.

In 2 cases of wound in the gum 2 days after tooth extraction, 2 showed spirilla, or spirilla and fusiform bacilli.

The numbers of spirilla and fusiform bacilli varied from only a few in the film to enormous numbers, giving the typical appearance as described by Vincent. The last were three in number, and I will describe them in detail.

One was a case diagnosed as septic scarlatina with ulceration of the fauces. The spirilla and fusiform bacilli were present in numbers greatly in excess of any other organisms, but the case pursued the ordinary course of septic scarlatina, and films two days later no longer showed the typical Vincent's organisms.

The two other cases were children, æt. 7 and 8, convalescent from scarlatina. Yellowish patches appeared on the tonsils, in one case on both sides, and films showed only a few cocci amongst large numbers of spirilla and fusiform bacilli. These persisted four or five days and disappeared at the same time as the lesion. Neither of these cases showed any symptoms whatever. There was no rise of temperature, and no loss of appetite. Repeated cultures from the throat failed to show diphtheria bacilli, and there were no later complications. In addition to films from the throats, I was also making films from the detritus between healthy teeth. In no case where spirilla were found in the throat were they absent from the teeth. I also made films from the teeth of healthy children convalescent from infectious disease, and in 40 cases found spirilla in 29. From 10 healthy adults similar results were obtained in 6 cases.

As to the methods employed, I stained either with carbol gentian violet, or with carbol fuchsin. In about one quarter of the cases I examined hanging drop preparations for motility of the spirilla. This was very marked in some cases when taken from the throat, but was variable and may be mentioned as a character which seemed to distinguish the spirilla from the teeth from those from throat lesions. As to the identity of the organisms of the teeth with those of the throat, I have no evidence except that in all cases where they were present in the throat, they were also in the teeth. These organisms were present in considerable numbers in the cases of follicular tonsillitis, and when I examined exudate squeezed out from tonsillar crypts, which were not inflamed, they were present in each of the three cases. This occurrence of varying numbers of spirilla and fusiform bacilli in cases other than Vincent's angina is, of course, admitted by Vincent, who says that like other pathogenic microbes, they may occur as inhabitants of the mouths of healthy subjects.

<sup>(</sup>a) Paper read at the Buxton Meeting of the Royal Institute of Public Health, July, 1908, and printed in the Journal of the Institute in November, 1908.

I will now review the facts concerning the supposed effects of these organisms. Those interested in the questions of priority will find communications on the subject from Dr. H. Plaut, of Hamburg, and Professor Vincent in the Gazette des Hopitaux for February 14th, 1905. Professor Vincent gives a fairly complete account of his organisms and the angina of Vincent in the Lancet for May 13th, 1905. He distinguishes two forms of the angina. The first he calls the diphtheroid. The false membrane, adenitis and fever, make one think of diphtheria, but the bacteriological examination shows that it is not. In this variety the fusiform bacilli is found alone, or in association with streptococci, staphylococci, etc. He adds that it is important to remember there are cases in which the true diphtheria bacillus is associated with the symbiosis of the fusiform bacillus and spirillum.

The second form is the ulcerative membranous. In this the bacillus and spirillum are associated. There is malaise, headache and fever with injection of a tonsil. Soon examination of the throat shows a greyish or yellowish false membrane soft, not very thick and not very adherent, and beneath there is ulceration. The breath is fœtid and swallowing is difficult and painful. The submaxillary glands are enlarged. This angina lasts eight days or more, it sometimes affects both sides. Accompanying this form there may be a scarlatinal erythema and some times a pseudo-rheumatism. In the course of the disease albuminuria, myocarditis and endo-carditis may appear, but these complications result from an added infection, usually strepto-coccal. There is also described by Queyrat in the Gazette des Hopitaux, January 17th, 1905, a case which he says it was impossible, clinically, to distinguish from syphilis except by bacteriological examination, which showed it to be a case of Vincent's angina. Vincent himself, however, says that it is important to remember that secondary and tertiary syphilitic lesions may be infected secondarily by the fusiform bacillus and spirillum. But he considers that lesions which are true Vincent's angina may resemble syphilis, and only the result of treatment makes the diagnosis certain.

Lastly, I may add my own two cases in which bacteriological results were obtained typical of Vincent's angina, and in which there were no symptoms whatever, and the only signs were the small, yellow tonsillar patches. It seems to me, therefore, that before the possibility of this variable pathogenic influence is granted, there should be considerable evidence in its favour. There are certainly cases on record in which persons using the same tobacco pipe or having been in intimate contact have suffered, one after the other, from sore throats in which Vincent's organisms have been discovered, but as the organisms occur so frequently, such evidence must be on a large scale to be absolutely convincing.

An inoculation has been made on the wounded mucous membrane of the prepuce from the infected mouth of a patient and from the membrane growing on the site, Vincent's organisms were found in profusion in association with others; but there is no certain proof that the other organisms were not the more important factor. As to the effects of the inoculation in animals, Professor

Vincent himself, using impure preparations in which cocci were present, produced by subcutaneous injection abscesses, sloughing, and in some cases, wasting and death. Both cocci and fusiform bacilli were recovered from the lesions. Tunnicliffe, however, using pure cultures, did not get any pathogenic effects, and Lehmann and Neumann, quoting Mühlens, say that neither subcutaneous nor intraperitoneal injections into mice, rabbits, or guinea pigs showed pathogenic effects.

The question arises as to the relation of the fusiform bacillus in the spirillum. Professor Vincent regards it as most probably a case of symbiosis, but some consider that the spirillum arises from the bacillus, and Tunnicliffe in an apparently pure culture of the bacillus found the spirillum appearing. This result has been criticised, and I am not aware that it has been confirmed. It is, of course, possible that there is a large group of fusiform bacilli and spirilla which vary in their pathogenic characters as groups of other organisms are found to do so. Apart from this theory it seems to me that the evidence in favour of the pathogenicity of Vincent's organisms is not strong enough to enable one to consider it proved. That they can flourish as parasites is certain, but they are found in cases of widely different clinical appearances and in a class of case notoriously difficult to diagnose, and also, they are often found in association with organisms known to be capable of producing the pathological conditions seen. They are also found in numbers varying from only a few in a film to such numbers as to practically fill the field. Professor Vincent, himself, acknowledges their presence in the mouths of healthy subjects and that they grow profusely in lesions which they have not caused. The only inoculation experiments with pure cultures that I am aware of were negative. On the other hand, taking a tonsillotomy wound in a healthy subject as a simple wound in the mouth, I have not obtained a typical film from the exudate which forms during the days following the operation, though in two cases, fusiform bacilli and spirilla were present in small numbers. Only five opportunities, however, have occurred of trying this.

In conclusion, I must thank Dr. Knyvett Gordon, and Dr. Alfred Greenwood for allowing me to use cases in the hospitals of which they are superintendents.

#### ON THE USE OF

### DIGITALIS IN DISORDERS OF THE PERIPHERAL CIRCULATION.

By J. T. MACLACHLAN, M.D., Assistant Physician, Glasgow Royal Infirmary.

During the present winter I have been impressed with the number of patients who suffer from cold feet and hands. In cold weather their hands are almost livid red, and the face deeply congested with a bluish tinge. Such patients are apt to suffer from chilblains, going on occasionally to trouble-some ulceration. Bunions and corns, too, appear to me to be especially common in such patients. The pulse is soft and easily obliterated. It appears to me the condition is not one of weak heart so much as lack of tone in the arteries. In those cases digitalis acts like a charm, and it is astonishing to find, after a week's treatment by digitalis, the condition is promptly relieved. But it is essential to

prescribe a reliable preparation of digitalis, and I have found Parke, Davis and Co.'s digitalis give

A somewhat similar condition is present in young women suffering from gastric ulcer, and I cannot help thinking that the defective peripheral circulation has an ætiological bearing. I feel tolerably certain that the addition of digitalis to the other remedies is of essential importance.

Again, in patients the subject of phthisis pulmoralis the pulse seems to me to partake of the characters described above; but, once again, digitalis is useful. It is a significant fact that tubercle is apt to deposit at the apices, and, as far as I can judge from clinical observation, at the points where the lungs divide into their lobes.

The tendency to enlargement of the terminal phalanges, or, indeed, of the whole hand, may be

related to a tardy peripheral circulation.

Apart from these disabilities, patients with the state of the circulation I am attempting to describe enjoy a happy optimistic state of mind, while those with very tense arteries are frequently depressed, moody and irritable.

Ulcers on the legs or hands, persisting in consequence of a poor peripheral circulation, often take a "turn for the better" when the circulation is improved by the administration of digitalis.

Vertigo is very common in persons the subject of heart disease, and anyone complaining of it should receive a careful examination, for valvular disease will be frequently discovered, and will furnish the key to the successful treatment. The circulation of blood through the brain is evidently disturbed, and once again cardiac tonics are neces-

We are apt to look upon the circulation of the blood as being entirely an affair of the heart, whereas I believe the muscular coat in the arteries is no less necessary in maintaining it in an efficient state.

#### **OUT-PATIENT'S ROOM.**

ST. THOMAS'S HOSPITAL.

Demonstration upon a Case of Abdominal Pain.

By EDRED M. CORNER, M.C., F.R.C.S.

This is the case of a woman, æt. 25, who has had an appendix abscess opened and drained two years ago. The scar is just above and parallel with l'oupart's ligament. Lately she has developed attacks of abdominal pain, due to peristalsis of the bowels, coils of which can be felt to rise and harden under the hand during The abdomen becomes distended with gas, her attacks. and when flatus is passed the attack is relieved. There is no sickness, only eructations. The attacks last from 10 minutes to an hour, and are accompanied by a weak, rapid pulse, with blueness of the extremities. abdominal examination of the patient reveals little of importance except a little resistance on the inner side of the operation scar. Per rectum, no tumour can be felt; the uterus and adnexa are healthy. In the absence of definite physical signs, it is necessary to rely upon the patient's history and our own experience to give advice. Since Christmas, 1908, I have had no less than three somewhat similar cases, and as they illustrate the reasons upon which my advice to the patient is based, I will briefly recall them.

The first was a man of 40 years of age, admitted to the hospital for acute intestinal obstruction of eight days' duration. The man was, naturally, exceedingly ill, and it was doubtful if it was worth his while to be operated upon. It was decided to give him the chance. The abdomen was opened through the right rectus muscle, and the cæcum found to be collapsed. The appendix was adherent to the mesentery of the ileum, and from this point a band encircled and obstructed the small bowel. There is no doubt that this band resulted from previous appendicitis. The poor man died 12 hours later, never recovering from the operation. The post-mortem examination confirmed

the observations made at the operation.

The second case was one of Dr. Underhill's patients at Herne Hill. I had removed the appendix for recurrent attacks of appendicitis a year before. He had now intestinal obstruction of a week's duration At the operation no time was lost in finding the obstruction, as the first case had taught me. There was a band extending from the mesentery across the small bowel, obstructing it, about a foot from the cæcum. It was divided, but the man never rallied from the operation, dying a few hours later.

The third case was one from whom the appendix had been removed two years before by another surgeon. It was that of a young man with nine to ten days' history of intestinal obstruction. At the operation an obstructing band was found across the ileum, about 16 in. from the cæcum, precisely as in the other cases. It was relieved, but the man never rallied, dying six hours later.

These cases agree completely on the following clinical points, and, in doing so, accentuate their importance:—
(1) The causation of the intestinal obstruction was appendicitis; in two cases the appendix had been removed; in one it had not. (2) The band causing the obstruction was over the small bowel, a few inches from the cæcum. (3) The consequent obstruction was incomplete, the symptoms slight, so that the cases went over a week before coming to operation. (4) All died, rever rallying from the operation, in consequence of the long illness entailed. (5) The obstructing band had arisen from an adhesion between the small bowel and its mesentery, in consequence of an attack of appendicitis. The adhesion became drawn out into a band by the peristalsis of the intestine.

It is a very old teaching that cases that do badly instruct us much more than do cases that do well. This is a doctrine which is very true in the present instance, because the three fatal cases just narrated form the basis for advising this woman to have an exploratory operation. If my diagnosis is true, the three men who have died have helped this woman. The diagnosis made is that of partial intestinal obstruction from adhesion of the ileum near the cæcum, the consequence of the previous attacks of appendicitis. I may add that the patient has been examined by physicians, who regard her trouble as "functional," and her dislike to the ward discipline suggests that also. But there is reason to doubt if her whole trouble is functional. It may very well be a mixture of sub-acute intestinal and neurasthenia which may have resulted from it. treatment of the case has been decided. She is to be treated with regular diet, mental and bodily rest, regulation of the bowels, and general discipline. If definite attacks of partial intestinal obstruction occur, the abdomen will be explored and the band divided; or if, instead of a band, multiple adhesions are found which, if separated, will re-form, it will be better to make a lateral anastomosis between her ileum and het transverse colon.

#### OPERATING THEATRES.

ITALIAN HOSPITAL, QUEEN SQUARE, W.C. OPERATION FOR ACUTE APPENDIX ABSCESS, BY T. P. LEGG.—A man, set. 30, was admitted, complaining of pain in the right side of his abdomen, and having also a temperature of 1010. He had been quite well up to a few days before coming to the hospital. The pain came on very suddenly and severely. He was not sick, and, on examination, was found to have rigidity in the right iliac fossa and extreme tenderness on palpation; no tumour was detected. The rest of the abdomen was a little distended, but otherwise normal; the pulse was 100, tongue clean. During the course of the next two days the temperature and the pulse came down to normal, and he appeared to be much better. On the sixth day of his stay in hospital the temperature rose suddenly to ioi.9° in the evening; next morning it was 102.4°, and he was much worse. The pain and rigidity had returned, the abdomen was distended, and

a definite swelling was found in the right side of the abdomen. This swelling was behind the rectus muscle; its lower limit was a little below the level of the anterior superior iliac spine. It measured about 3 in. transversely, and 4 in. from above downwards, and was resonant on percussion. There was no swelling in the right iliac fossa, and no resistance in this situation. Operation was undertaken at once, an incision 3 in long being made over the centre of the swelling. On opening the peritoneal cavity, no adhesions were found. opening the peritoheat cavity, no additional states of the distended and inflamed ascending colon presented, and on its inner side an elastic swelling was felt, covered by small bowel. The colon and the small intestine were pushed off the swelling by means of the general states of the general states. gauze packing, which also served to shut off the general peritoneal cavity. A short incision was then made into abscess, and several ounces of fæculent pus were slowly evacuated, the pus being mopped up as it escaped. After all the pus had been evacuated, the incision into the abscess cavity was enlarged, and the finger inserted to see if the appendix could be felt or if there was any concretion lying loose. Neither the appendix nor a concretion was detected. A large drainage tube was placed in the cavity and packed round with gauze. An outside dressing having been applied, the

patient was sent back to bed. Mr. Legg said that this case was an excellent example of an abscess due to appendicitis, occupying a high position behind the colon. It was not a very uncommon position, and the case illustrated the usual signs of such abscesses. In these patients there were frequently no adhesions shutting off the general peritoneal cavity, and hence, in operating on them, one had to very carefully pack off with gauze the peritoneal cavity before opening the abscess. Moreover, in opening the abdomen, the presence of distended and inflamed intestine in front of the abscess must not be forgotten,

and, if care is not taken, the bowel may be wounded either on dividing the parietal peritoneum or in opening the abscess if it is not carefully and sufficiently displaced. It was always best to make a small incision into the abscess; the pus can then be easily mopped up, and the whole wound is not flooded by it. By doing it in this way, Mr. Legg thought that the chances of infecting the general peritoneal cavity were much diminished. After the evacuation of the pus, the incision should be enlarged sufficiently to permit of a finger being inserted to feel for any loose concretion. Mr. Legg did not approve of making a search for the appendix by breaking down the adhesions and the abscess wall. He thought it was much more preferable

to leave the appendix alone, and, when the wound had healed, to remove it by a second operation. This was usually necessary, experience having shown that in these cases the appendix was so destroyed that the whole or greater part of it would be found to be chronically inflamed and capable of determining the formation of another abscess. Of course, if the appendix could be seen and felt when the abscess was opened, it was right to remove it, but this was not the same thing as searching for it by breaking down the abscess wall. Mr. Legg also did not think any advan-tage was to be gained by washing out these foul abscesses. He trusted to the drainage by means of a

large tube, and in the course of a few days the pus soon became odourless. The gauze packing would be removed on the fourth or fifth day, and replaced by a smaller quantity packed around the drainage tube, which would be gradually shortened.

The case clinically was interesting, because the patient after his admission seemed to make a rapid recovery; the temperature and pulse came down to normal, and the abdominal signs cleared up. Then suddenly he became very ill, the temperature and pulse rapidly rose, and the signs of an abscess were evident. This type of case was not uncommon, and the danger arose from their deceptiveness. One must suppose the abscess had been deeply placed and slowly forming all the time, and that suddenly it rapidly increased. Had the patient not been kept in bed the whole time, and carefully watched, the results might have been fatal. A patient who has had an attack of appendicitis, with high temperature, should always be kept in bed and closely watched for days after the symptoms have sub-

sided, and when a rapid recrudescence of the symptoms occurs, the presence of an abscess should be carefully looked for, and the necessity of an immediate operation borne in mind. Repeated examinations of the blood for a leucocytosis should be made, and in this patient there were nearly 20,000 on the day of operation.

It is satisfactory to record that the man made an

uninterrupted recovery.

#### TRANSACTIONS OF SOCIETIES.

CHELSEA CLINICAL SOCIETY.

MEETING HELD FEBRUARY 16TH, 1909.

The President, Mr. A. F. PENNY, F.R.C.S.I., in the

A PAPER was read by Dr. ALFRED EDDOWES on BOOTS, AND THE TREATMENT OF CORNS AND PLANTAR WARTS,

which will be found elsewhere in the present issue

(page 215).

Dr. FIRTH PALMER maintained that the prevention and cure of corns was perfectly simple, and that nine-tenths of the suffering in the world resulting from corns was due to the existence of chiropodists. The painful warts referred to by Dr. Eddowes he thought

largely the result of cutting corns.
Dr. Marsh was sceptical as to the possible value of

the Alexandra corn rubber.

Dr. SIMMONS took exception to all the boots recommended by Dr. Eddowes. He had never been able to obtain a suitable boot in this country, and always ordered American ones

Dr. Eddowes replied.
Dr. Victor Bonney read a paper on SOME USEFUL PRESCRIPTIONS IN THE PRACTICE OF GYN.ECOLOGY.

Gynæcology was almost a purely surgical art, but there were a certain section of patients who refused the administration of drugs either as an adjuvant or as an alternative to operative measures. It was possible as an atternative to operative measures. It was possible to divide the women attending an out-patient clinic into (1) those who had physical signs of disease, and (2) those who had none. It was the last group in which drug treatment was chiefly indicated. Of the drugs in the gynacological materia medica, ergot was by far the most useful. It was the only one possessing a completely specific action. He had found it most active in acid solution, and combined with strychnine. There were certain contra-indications to its use, of which the most important were—(1) it should not be used as a treatment for uterine fibroids. These tumours should be removed by operation as early as practicable. The continued use of ergot by increasing arterial tension threw an increased strain on the cardiac muscle, already degenerate from chronic anæmia. The dilatation that ensued militated against the success of the almost always inevitable operation. (2) It should not be used as a treatment for incomplete abortion. The proper treatment was uterine exploration. To waste time giving ergot increased the risk of sepsis. (3) It was a useless drug in diffuse fibrotic metritis. In these cases, as a result of chronic inflammetrius. In these cases, as a result of chrome inflammation, the uterine musculature was degenerate, and ergot produced no effect in controlling the severe menorrhagia from which such patients suffered. (4) Finally, it should never be given to check uterine hæmorrhage without having first made a digital examination as to the cause of the bleeding. Neglect of ination as to the cause of the bleeding. this point was responsible for a large number of the inoperable cases of carcinoma of the cervix which came before a surgeon. There were several drugs having actions more or less akin to ergot. Of these the speaker had favourable opinions of the salts of cotarnin called styptol and stypticine. Hydrastis and cotarnin caused styptol and stypticine. Hydrastis and hammamelis were useful adjuvants, whilst he had had very good results with bryonia, especially in cases of menorrhagia associated with chronic pelvic pain. Cotarnin also had this pain-allaying property in a degree. Of the so-called "uterine tonics," the bromides

were the most useful. It was a curious thing that in women suffering from debility and pelvic pain the bromides acted as very efficient tonics, whilst strychnine was always disappointing in these cases. He had had very good results with aletris, especially when combined with bryony and the bromides. For dysmenorrhea various analgesic drugs were at the service of the gynæcologist. He preferred phenalgin amongst these. This failing, he fell back on some others in the list. The analgesics were of great use in virginal dysmenorrhæa, but much less so in the various acquired forms of the affection, while in the treatment of chronic pelvic pain they had no place at all. In these cases the bromides, aletris, viburnum, or cotarnin were indicated. Passing to the use of local applications, the speaker spoke highly of protargol in vaginitis. It was important in such cases to make direct application to the cervical canal as well. He discussed briefly the various forms of douche. For deodorant purposes the best form, in his opinion, was a Sanitas douche. Speaking of pruritus and its treatment, he mentioned the proprietary compound "zymocide," which had yielded admirable results in compound this affection.

### NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT LIVERPOOL ON FEBRUARY 19TH.

The President, Dr. J. W. MARTIN (Sheffield), in the Chair.

Dr. J. J. O'HAGAN showed a fibro-myomatous uterus, with bilateral ovarian dermoid cysts, which

had been removed by total hysterectomy.

Dr. J. E. GEMMELL and Dr. LEITH MURRAY (Liverpool) showed: (1) Myxo-fibroma of the vagina; (2) sarcoma of the great omentum, which had presented a soft solid, freely movable tumour in the left hypochondrium. It could be pushed into the pelvis, and had simulated a dislocated spleen. It was easily excised. There was no ascites, and the other excised abdominal organs were normal.

Dr. D. LLOYD ROBERTS (Manchester) showed a specimen of cystic fibro-myoma of the uterus, and read the notes of a case of Cæsarean section, performed, before the onset of labour, on account of a flattened pelvis (C.V. = 3 ins.). Craniotomy had been performed on three previous occasions. Involution of the uterus was slow, and on the eighth day symptoms of sepsis appeared. The uterus was explored and a large clot removed. Recovery was then uninterrupted.

In closing a discussion, Dr. LLOYD ROBERTS stated that he always, if necessary, dilated the cervical canal before suturing the uterine incision, that ergot was given during the operation, and that, in his opinion, the retention of blood-clot was due to pressure of the lower uterine symphysis against the promontory.

Dr. LLOYD ROBERTS also showed a recurrent tumour of the vagina, enucleated, piecemeal, from a woman, et. 43. Microscopically it consisted chiefly of fibromyomatous tissue, though one part suggested sarcoma.

Dr. J. E. Gemmell stated that, nine years before,

he had enucleated a vaginal growth, the size of a Jaffa orange, from this patient. Clinically he had considered it a sarcoma, but microscopically it had been described as a degenerating fibroid.

Dr. J. W. FITZGERALD (Manchester) showed the

specimen and read notes of a case of primary carcinoma of the vagina, occurring in a nullipara, æt. 26. The ulcerated growth, which occupied the left fornix, was freed from below and then removed, together with the uterus by the abdominal route. The patient made a good recovery. Section showed that the growth—an epithelioma—though invading the cervix, was not connected with the mucous membrane of the cervical canal. But it may possibly have arisen from the epithelial covering of the portio.

Dr. H. R. CLARKE (Manchester), in a paper on cavernous conditions occurring in the uterus, pointed out that the myometrium of the infantile uterus consists of a network of a fibro-muscular tissue, enclosing

large cavernous spaces, which are lined with endothelium and filled, in most of his specimens, with blood. During development arteries extend from the fibrous trabeculæ into these spaces, invaginating the venous wall and producing, in the early stages, a condition which the author likened to corpus cavernosum of the penis. The arteries grow more rapidly than the venous spaces, and so, by this process of condensation, the dense condition of the adult myometrium is reached, and the arteries of the adult uterus come to be surrounded by their venous spaces. The author suggested that the angiomatous changes seen occasionally in uterine fibroids may possibly be dependent upon this developmental process.

The paper was discussed by Dr. Blair Bell, Dr. Lloyd Roberts, and Dr. A. W. W. Lea, and Dr. Clarke replied.

#### ULSTER MEDICAL SOCIETY.

MEETING HELD THURSDAY, FEBRUARY 18TH, 1909.

In the absence of the President, Mr. T. S. Kirk, the chair was taken by Professor Sinclair.

Dr. MAGUIRE showed a case of acromegaly. The patient was a woman of about 45, with a history of the disease having started 15 years ago. The appearance of the hands and feet was quite typical. She had recently been operated upon for sarcoma of the lower jaw, and Dr. Maguire said that the idea naturally occurred to one that this might have been secondary to a tumour of the pituitary body. But he could find no evidence of such a tumour, and Dr. Cecil Shaw, who had kindly examined the eyes, found no defect of sight. The larvnx could not be seen, owing to the large size of the tongue and the patient's inability to open the mouth widely. A curious feature was the functional activity of the mammary gland, from which milk could easily be squeezed, though it was four years since a child had been nursed. Dr. Maguire showed excellent skiagrams of the hands and feet, which his

colleague, Mr. O'Doherty, had done for him.
Captain Archer, R.A.M.C., showed two cases. The
first was a soldier suffering from what seemed to be irritable heart. The heart ran at about 160, the impulse almost imperceptible generally, with every sixteenth beat or thereabouts very strong. The only point in his history throwing light on it was that just before coming into hospital he had overstrained himself in a long march. The second case was one of persistent pain after a fracture of the clavicle, due apparently to involvement of the brachial plexus.

Dr. Calwell opened a discussion on GASTRIC ULCER.

After considering its distribution, and the age and sex of patients, he made several divisions of the ailment, according to the nervous symptoms, migraine, etc., accompanying it, or the symptoms of infection of the alimentary canal. He emphasised the importance of early treatment, and specially of rest. Referring to chronic ulcer, he asked the opinion of his surgical colleagues as to the indications for operation. His own opinion was that where the surgeon could relieve a mechanical difficulty he did good, but not otherwise.

Professor Lindsay discussed the foregoing remarks,

and laid special emphasis on the differential diagnosis of ulcer from gastralgia.

Dr. DEMPSEY said he was not convinced of the advisability of making the various classes of ulcer which Dr. Calwell had named. After his remarks it was agreed to adjourn the discussion till the next

#### CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, FEBRUARY 25TH, 1909.

Dr. CHAMPNEYS in the Chair.

THERE were also present Dr. Stanley Atkinson, Mrs. Latter, the Hon. Mrs. Chas. Egerton (who has been appointed by the Privy Council in the place of Miss Wilson, resigned, Miss Paget, and Mr. Parker Young. Letters were read from the Registrar of the Royal

College of Surgeons reporting that Dr. F. H. Champneys had been reappointed to represent the College on the Board, and from the Clerk of the Society of Apothecaries of London stating that Mr. Parker Young had been reappointed to represent that body. Frederick Edge, M.D., F.R.C.S., Wm. Gough, M.B., F.R.C.S., and (pro hdc vice) George Raymond, M.B., were approved as teachers; and Dr. J. D. Barris, of the City of London Lying-in Hospital, was appointed as one of the Board's supernumerary examiners.

A letter was read from the Clerk of the Council, stating that, in the Lord President's opinion, the practical objects of the Midwives Act Committee would not be served by the addition to its numbers of repre-

sentatives of special interests.

Mr. PARKER YOUNG moved a resolution of regret at this decision, which was seconded by Dr. ATKINSON, who remarked that the Privy Council had just appointed a representative of special interests in the person of a County Medical Officer. The resolution was passed, nem. con.

suggestion from Mrs. Hobhouse "that all Registrars of Births should add in a new column the name, status, and address of the person who delivered the child," met with the approval of the Board, and it was agreed that the Registrar-General should be asked to issue the

necessary instructions.

In view of the correspondence which has arisen on the subject of vaginal examinations consequent upon instructions recently issued by the Board to training schools and teachers, the following circular has been issued, signed by the Chairman:—

VAGINAL EXAMINATIONS—RULE C. I. (1).

Inasmuch as misapprehension seems to exist with regard to the meaning of Rule C. I. (1): "She must have . . . attended and watched the progress of not fewer than 20 labours, making abdominal and vaginal examinations during the course of labour" (see also schedule, Form III.):-

The Board wishes to point out that the word "exam, inations" (in the plural number) is to be taken in connection with the word "progress," and as implying such a number of examinations as will enable the pupil to "watch the progress of the labour." The word "frequent" is advisedly not used.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 28th, 1909.

FULGURATION.

The treatment of cancer by fulguration seems to have been definitely adopted by French surgeons.

The term "fulguration," invented and applied by Dr. Keating-Hart, is an electro-surgical operation which, as its name implies, is divided into two periods —the operation proper and the application of the electric spark of high frequency.

These manœuvres being very painful, local or general

anæsthesia is necessary.

The patient being placed under the influence of an anæsthetic, a preparatory application of the electric spark is made so as to soften the tissues of the neo-plasm to render them more amenable to the curette and anæmify the surface.

Immediately after this fulguration, the tumour is excised with the bistoury and the raw surface carefully scraped with the curette. Fulguration is then practised, which has for almost immediate effect the arrest of

Keating-Hart uses a special electrode of his own invention to operate. This electrode is either straight on curved, so as to be able to act in every region. The spark does not act solely by the heat it develops in burning the morbid tissue; the cells of the neoplasm melt, so to speak, under its influence, while it stimu-lates the vitality of the neighbouring healthy tissues.

The duration and dosage of the sparks are difficult

to fix precisely, as a great deal depends on the operator, his experience in fulguration, and the immediate effects on the tissues. In any case, no portion of the wound should be neglected, and the edges particularly should receive special care.

Almost at the beginning of the fulguration the hæmorrhage is rapidly arrested; the surface becomes white, but soon afterwards it takes on a blackish-grey aspect. The operation terminated, the

dressed.

Dr. Keating-Hart insists on two very important points: First, each time that it is not possible to completely remove all the cancerous masses the region must be submitted to continued refrigeration by means of the ice bag or an uninterrupted current of iced water; secondly, oxygen water only must be used, more or less diluted, for washings and dressings.

In cases where dry dressing is sufficient, he powders the wound with perborate of soda. A few days after the operation. ordinary antiseptics, such as iodoform

and aristol, may be used.

As to the consecutive phenomena, the first to be noticed are complete and absolute suppression of pain, and an extremely abundant secretion of the wound. requiring the dressing to be changed several times a day, followed a few days subsequently by active granulation. The wound is completely cicatrised in from eight to ten weeks.

Dr. Bizard, who has made a special study of this treatment, says that, although fulguration cannot be applied indistinctly for every visceral or cutaneous cancer, yet it cannot be denied that it constitutes an excellent method for a whole group of neoplasms which were hitherto regarded as entirely inoperable. It is the only method which allows hope to be entertained for the most desperate cases, such as cancers of the face invading the cavities and gaining the osseous canals and inaccessible infractuosities which have resisted every treatment, medical or surgical.

One great advantage of this new treatment of malignant disease is that it is absolutely inoffensive, since Keating-Hart used it in over 200 grave operations

without one accident.

#### IMPETIGO AND NEPHRITIS.

Impetigo in children is frequently accompanied with nephritis, the result of the cutaneous lesion; the impetigo disappears first, and afterwards the symptoms of the renal complication.

Two clinical types are observed—the transitory and the acute form.

The first type is found in cases where only slight symptoms are noticed, and which are only confirmed by examination of the urine. The presence of albumin is the only symptom. The quantity varies between 10 and 15 grains to the quart, but it can become more abundant. Hæmaturia has been observed histologically by microscopic examination, but sometimes the amount is sufficient to colour the urine. The sediments observed under the microscope, besides the red corpuscles already mentioned, are epithelial cylinders and hyalins. The other symptoms usual to nephritis are absent; neither œdema, cardiac trouble, nor uræmic symptoms are observed. Definite recovery is the rule.

Otherwise serious, says Dr, Girard, is the nephritis beginning either by the skin or the lower limbs, and

sometimes general anasarca has been observed.

Besides these cases, there are others where the cedema. is hardly perceptible; a puffiness of the face and a waxy colour of the skin would represent all the abnormal signs The heart is in no way disturbed, and nothing is found in the lungs, but examination of the urine reveals the presence of a more or less large quantity of albumin.

In grave cases of renal complications, with impetigo, the child is pale and very thin, the eyelids somewhat puffy, the abdomen large, with voluminous liver, the heart dilated, and the pulse rapid and irregular; urine high in colour, dirty, and contains about a drachm of albumin to the quart.

A serious complication is possible in the course of this nephritis. Cardiac symptoms may supervene, producing uramic symptoms which put the life of the patient in grave danger, anasarca, oliguria, dyspnœa,

epistaxis, vomiting, etc., as were observed in cases cited by Muller and Marfau.

In the course of impetigo, nephritis is consequently a complication that should not be overlooked; the urine of every child suffering from impetigo or impetigenous eczema should be examined, and an appropriate treatment in the case of the existence of albumin prescribed.

On the rapidity of the diagnosis, and consequently on the efficacy of the treatment will depend the nature of the prognosis. Benign in the majority of cases, it can become very grave, this being due, perhaps, to a special virulence of the infectious germs at the seat of the cutaneous lesion, or to the general weakness of the patient.

In any case many of the complications can be

avoided.

GONORRHOBA. Salol, Urotropin, gr.

Santalol, 4 gr. For 1 capsule, 6 to 12 daily.

The simultaneous administration of urotropin, salol, and santalol seems to have an excellent effect on acute or chronic blennorrhagia. It can be commenced at the very outset, and prolonged without inconvenience to the general health.

#### GERMANY.

Berlin, Feb 28th, 1909

At the Medical Society, Hr. Unger showed a dog in which, ten days previously, he had removed both kidneys, as well as the ureters, and a portion of the aorta and vena cava, implanting in their places the corresponding parts of another dog. The animal was apparently doing very well.

The discussion on Hr. Albu's paper on VISCERAL PTOSIS AS A CONSTITUTIONAL DISEASE

was then continued.

Hr. Kausch remarked that the thorax phthisicus and the thorax paralyticus were not identical. The former had certain distinguishing marks at the upper aperture which were wanting in the latter.

Hr. Bönniger considered splanchnic ptosis to be a result of space conditions; it was therefore dependent on the form of the lower thoracic aperture. Normally in the infant the organs lay very low; it was only when the liver, which was at first very large, became reduced to the proportions of later life, and space was obtained there, that they rose higher. The most favourable means of avoiding splanchnic ptosis lay in raising the capacity of the lungs by corporeal development of the child, and thereby influencing the form of the

thorax in a favourable manner.

Hr. L. Landau considered splanchnic ptosis, with few exceptions, not to be a congenital disease, but one caused in later life by mechanical or anatomical changes; movable kidney, or liver, spleen, or other organ was not a secondary, but an independent affection. It occurred through the giving way of the means of fixation. As regarded the liver, the ligamentation exceptions of the secondary of mentum ersonarium, or teres, or rotundum played as insignificant a part as the round ligaments of the uterus; they could at most prevent extreme displacements. For the purposes of fixation, the space in the abdomen, the amount of fat, and the abdominal walls were more to be considered. This view was important also as regarded treatment. From this point of view it was of no use to fix up one prolapsed organ; it was much more important to strengthen the abdominal muscles by exercises. During the intervals of treatment and whilst at work a corset or bandage might be

Hr. M. Mosse thought that anatomical examinations were wanting for the statements made by Albu, as percussion did not always give the limits of the stomach and intestines, especially in infants. Ptosis of the abdominal organs might be either congenital or acquired. The latter was not generally an object for treatment, as it did not, as a rule, cause any symptoms. Prophylaxis was the best treatment, a proper supervision of the corporeal development.

Hr. Posner had repeatedly observed renal palpatory albuminuria. This might be of importance; even

renal hemorrhage might take place from energetic pal-pation of a movable kidney. One should be careful, therefore, not to do harm by abdominal massage, or allow bandages to be worn that caused a constant pressure on the kidneys. Hr. Fuchs drew attention to the muscular weakness present in various parts of the body in patients who suffered from splanchnic

After Hr. Albu's reply, Hr. Hartog followed with a NOTE ON EARLY GETTING-UP AFTER LAPAROTOMY. In his remarks he endeavoured to combat the objec-

tions that were in force in regard to allowing patients to get up quickly after laparotomies. Hæmorrhages and giving way of the wound should be guarded against by careful technique, the wound being covered by a plaster dressing and a supporting bandage. Small emboli were possible, but only during the early days when the thrombus was fresh, and soft, and harmless. In his own experience thromboses were less frequent with early getting-up. Besides this, there was the advantage of earlier convalescence, and earlier spontaneous action of the bowels, when, if the patient was to be allowed to get up early after operation, it was a necessary condition that the wound should have healed by first intention, and that there should have been no fever. The will of the patient, too, counted for a great deal. The speaker did not think it right to permit a patient to get up before the third day, and she should not be allowed to leave the klinik before the fourteenth day.

## AUSTRIA. Vioana, Feb. 28th, 1909.

ATRESIA RECTI.

Moszkowicz showed an infant one month old to the Gesellschaft on whom he had operated for atresia of the rectum. He first made an opening into the left iliac fossa, where the flexura sigmoidea was opened, from which a large quantity of meconium was discharged without any subsequent peritonitis. After the child had recovered, and the bowel fairly emptied, an attempt was made to complete the opening at the rectum on the seventeenth day, where a normal exit of the fæces could be accomplished. Before commencing the operation, the cul-de-sac was washed out, and a fluid solution of metallic bismuth poured in through the fistula, and the whole afterwards examined by the Röntgen rays. It was then seen that the cul-de-sac passed down close to the perinæum, into which a pair of forceps were placed, and the part distended so that a circular opening could be made from the outside to form an anus. The mucous membrane of the bowel was then brought down and attached to the outer skin. The child has since been able to pass its stools by the natural channel, while the fistula closed without any other interference, but has now a tendency to narrow the lumen of the bowel.

NEURO-FIBROMATOSIS.

Zumbush next presented a man, æt. 22, with a large, dark, hairy, pigmented mark on the left cheek and temple. These thick, dark, bristly patches were strewn over the trunk and arms, ranging from the size of poppy seeds to the palm of a hand. They were sharply defined, and the texture of the skin in the neighbourhood was unchanged. In these patches were concentric rings rising in tiers, having a livid colour, and hard, but some of them were soft and could be pressed level with the healthy skin when the finger was drawn across the two surfaces and then became quite indistinguishable to the observer. The right tibia from the middle outwards had a sabre appearance, while posteriorly it was crooked and irregular, with a pes planus valgus of the foot. The fibula under the Röntgen ray appeared as a thin withe, but not bent or irregular like the tibia. He considered all these changes as congenital morbid productions.

#### ERYTHEMA INFECTIOSUM.

Escherich presented two children with what is known as erythema infectiosum, which, he considered, would be more correctly described as erythema multiforme. These children had a rash resembling scarlet fever and measles combined. It is epidemic, and attacks children from 4 years to 12. The youngest patient he has ever seen suffering from the disease was 14 months. The

rash appears on the face without any constitutional prodroma in the form of bluish red, slightly elevated patches of erythema, extending from the alæ of the nose to the ears, but preserving the forehead in a great measure. The lymphatics below the ears are usually tender and painful to the touch. Along the extensor side of the limbs, as well as the gluteal region, the measle rash in large patches is met with, but it is less pronounced, and not so well defined over the trunk. It usually lasts from 8 to 14 days, with varying intensity, having a reticulated marble appearance before disappearing. Lymphatic enlargement, except those below the ears, mucous catarrh, and general disturbance, are all absent; neither are there sequelæ or other complications arising to retard recovery. It is evident that scarlet fever, measles, or rötheln may be easily confounded with the disease from its frequent recurrence and general appearance during an epidemic of measles. Some authors, like Hebra, draw distinctions between this infectious disease and erythema multiforme, although both agree in the localisation and efforescence of the rash, but differ in respect to contagion, affirming that erythema multiforme is not infectious, while exthema infections in Factorial and the statement of tious, while erythema infectiosum is. Escherich expressed some doubt about the contagious nature of the disease, as he has frequently met with it in different departments of the hospital, where it should, in all probability, have spread, but was easily confined to sporadic individuals. He thought we might easily retrace our steps and place both of these morbid changes under crythema multiforme.

Ehrmann concurred with Escherich that this was only an abortive form of erythema multiforme exsuda-

tivum, and not an acute exanthemata.

### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE CARNEGIE TRUST.—The Report of the Trust for the year 1907-1908 has been awaited with peculiar interest, because the end of the academic year with which it deals marks the close of the first quinquennial period of its operations, and, with the coming year, a new scheme of grants comes into force. A new denew scheme of grants comes into force. A new departure was made by the Trustees in admitting the Press to their deliberations, and the wide publicity which has thus been given to the speeches of the chairman, Lord Elgin, and Mr. A. J. Balfour, renders it unnecessary here to do more than refer to some of the salient features of the Report and meeting. It is especially interesting to observe how, in the opinion of all concerned, the endowment of research ranks in importance above the provision of better equipment, and far above the payment of class fees. In regard to the last-named department of their work, the Trustees have been guided by two principles: first, an adequate and uniform test of preliminary education; and, second, conditions of University study such as shall best serve the educational interests of the beneficiaries. These principles are now on the point of becoming fully operative. It will be remembered that in the trust deed Mr. Carnegie expressed the hope-or perhaps rather merely the opinion—that some part of the class fees would ultimately be refunded by the beneficiaries. This has been done by 55 out of a total of 8,263 students, the voluntary repayments amounting to £880 of a sum of £298,686 expended. The Trustees have been furnished with reports on the work of Carnegie scholars by Dr. Dobbie, Director of the Royal Scottish Museum

—Physics and Chemistry; Dr. Ritchie, Superintendent
of the Laboratory of the Royal College of Physicians, Edinburgh-Biology and Medicine; and Professor flume Brown—Historical and Economic. It is satisfactory to read that in nearly all cases the standard of work has been high. Dr. Ritchie expresses the opinion that in no corresponding period in the history of the Scotch Universities has so much research work on uniformly high standard been successfully carried on. He adds that the Trust is responsible for this development, and that without its assistance the work would in many cases never have been undertaken. Dr. Hume Brown refers to Mr. Duncan Mackenzie,

who has established a reputation as an archæologist; to Mr. Stevenson, who has made a new departure in Chaucerian study; and to Miss Mary Hamilton's treatise on incubation, as notable results of the Carnegie endowment. Dr. Dobbie says that, with few exceptions, the beneficiaries have fully justified their selection; the memoirs of their researches form no inconsiderable part of the literature of the past five years. Mr. Carnegie cannot but feel gratified by this universal opinion that his endowment of research has been, and still is, bringing forth so rich a harvest. In an appendix to the report a summary of the second quinquennial distribution (October, 1908—September, 1913) in aid of teaching is given. A sum of £40,000 anually is available. It is proposed to continue the library grant of £1,000 to each University; St. Andrews and Dundee £1,000 to each University; St. Andrews and Dundee are to get £10,000 for the equipment of the department of electrical engineering, and £500 for the pathological department. Lectureships on Economics, Geology, and History are to be endowed (£5,000 each). Glasgow has been awarded £13,500 to clear off debt on buildings, etc., in the Medical department, a professorship for Mesontile Low and lectureships on English of Mercantile Law, and lectureships on English, French, German, and Bacteriology are to be endowed (£26,500 in all). Contributions are also to be made to the West of Scotland Technical School, the Agricultural College, and Anderson's College Medical School. In Aberdeen no grants are being made for permanent equipment. Lectureships in Education, German, Constitutional Law, and History are being endowed. A sum of  $\pounds_{2,000}$  is granted to the North of Scotland Technical College. In Edinburgh grants in aid of permanent equipment are made to the Physics department, library, and anatomical museum; £4,000 a year is asked for to be set aside with the Currie Foundation of £17,000 to form a Lectureship Endowment Fund of £37,000; £13,000 is set aside to meet extensions of History. Grants are also made to the Heriot Watt College, to the School of Medicine of the Royal Colleges (£250), School (£250). and to the Women's Extra-Mural

BRITISH MEDICAL ASSOCIATION.—The Spring meeting of the Edinburgh and other Scottish branches was held in the Royal Infirmary on February 26th, and was attended by a large gathering of members. In the Museum a number of interesting exhibits were shown, and, as was the case last year, Dr. Cranston Low's series of casts of skin diseases attracted much attention by the fidelity with which he reproduced Nature. Patients were demonstrated at the clinical meeting by Drs. Chalmers Watson, Low, Farquharson, Cairshill, Byrom Bramwell, Gardener, Edwin Bramwell, Sinclair, Fordyce, Bruce, and by Messrs. Cotterill, Stiles, Caird, Dowden, Chiene, Stutthers, Wallace, Miles, and Scot-Skirving. Demonstrations of venereal diseases, eye cases, surgical out-patients, physical treatment of disease, and electro-therapeutics were also given by Mr. Miles, Dr. Mackay, Mr. Dowden, Dr. Webster, and Dr. Dawson Turner. In the evening the members dined together, the meeting being generally regarded as having been a very successful one.

#### BELFAST

BELFAST MATERNITY HOSPITAL.-The 115th annual meeting of this old charity was held last week, when Dr. Osborne, on behalf of the medical staff, read a report of increasing work on all sides. The new hospital, only opened some four or five years, is already becoming too cramped for the work, and an extension is talked of. The intern patients last year numbered 488, an increase of 110 over the previous year; there were eight maternal deaths, but in each case the patient was admitted in an almost hopeless condition. The extern cases numbered 416, and entailed 2,261 visits.. Sympathetic reference was made to the great loss sustained by the hospital in the death of Dr. Sydney Brice Smyth last summer.

SOCIETY FOR PROVIDING NURSES FOR THE SICK POOR. The annual meeting of this most excellent Society was held last week, and the report showed how finely the work is appreciated. The total number of patients nursed last year was 1,386, of whom 640 were sent by

doctors, including 43 cases where the nurses attended to assist at operations. The nine nurses employed paid no less than 35,800 visits. The work of these nurses does a great deal to relieve the congestion of the number of departments of the hospitals, as an enormous number of dressings of burns, etc., are done daily by them, which would otherwise go to hospital. The ladies who superintend the work of the nurses, and who are personally familiar with the cases, are probably the wisest and most discriminating almoners in the city: they see the home life of the people, and are not humbugged so often as clergymen are, so that the funds which they administer for special help in needy cases are most satisfactorily applied.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

THE NEWSPAPER PRESS AND QUACKERY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In his letter on this subject in your columns of February 17th, Mr. Henry Sewill has dealt chiefly with the evils resulting from the use of "indigestion cures" and "sham tonics." Every word he says is true, and there is no doubt about the greedy connivance of the titled (although not for that ennobled) newspaper proprietors who batten with swindlers upon the public credulity. The old saying, populus vult accipi, is now a recognised principle of trade, and a dozen noblemen of recent creation could be mentioned whose fortunes have been entirely derived from intelligent (i.e., impudent and cynical) advertising, the proceeds of which have enabled them to purchase their new dignities. All this, however, is the natural result of scientific evolution, of the application of psychology to trade, and is an example of the survival (the success) of the fittest, that is to say, of the cleverest.

One cannot withstand evolution, and restrictive legislation as suggested by your correspondent is not likely to be obtained if it interferes with such immense vested interests. Medical men would do better, moreover, than to count upon Royal Commissions and to remember the fons et origo of charlatanism is in the profession itself—in the practice of administering unnecessary medicines in the form of placebos, and of allowing patients to believe that the results, due to hygienic measures, employed concurrently with bogus medicines, are the effect of the imaginary remedies swallowed. How can we blame the public for believing in quacks after educating them in the doctrine that post is always propter hoc, and for supposing that an improvement which follows the taking of some advertised nostrum is really the result of the same? Further, is it logical to denounce with such acrimony the cures of Christian scientists, when we reflect that we have taught them to believe that consequences in medical practice are always the effects of the apparent causes—that is of the drugs administered. To eradicate popular superstitions concerning therapeutics, let us begin by reforming

medical ethics.

There is, however, one special category of quack medicines, the proprietors of which constantly exceed the limits of applied psychology and do not hesitate to apply fraudulent lying, and deception, to further the sale of their pernicious wares. I allude to many of the advertisers of cures for drug and alcohol addiction. A scandal of this kind, which was bolstered up by several dignitaries of the Church, and which was so public-spiritedly exposed, and at considerable

expense by yourselves, will no doubt be still fresh in the memories of many of your readers.

In looking over my cases, I find that most victims of the morphia habit have had their addiction prolonged and hope of ultimate recovery destroyed by the use of advertised cures. If the medicines sold, generally at the most extortionate prices, merely consisted of coloured water, as in the case exposed by yourselves, it would not so much matter; but the almost universal policy adopted by the scoundrels

who exploit these specifics is to give the purchaser in a disguised form the very drug they profess to enable him to suppress. This dodge is practised everywhere. An American gentleman, who afterwards became my patient, had come to Europe with a supply of a well-known remedy for which, believing in the statements of the clerical certifiers to its efficacy, he had paid the sum of \$100. Becoming ultimately suspicious, he had the contents of the numbered bottles analysed, and they were found to contain successively

decreasing quantities of morphia.

Another of my patients, a French scientist who was foolish enough to be tempted by a German prospectus, sent for the medicine advertised, but, recognising the nature of the fraud, he wrote to the proprietor taxing him with his deception. Receiving no reply, he took the train to Dusseldorf, intending to denounce the imposture to the authorities. This, however, had already been done, and the business stopped by the police. "They manage," he wrote to me, "these things better in Germany." He had, I should explain, been a few months before one of the innumerable victims, many of whose lives have been ruined by the substitution for morphia of heroin, which, thanks to the supineness of the French police, had been advertised extensively and sold under a pseudonym as a certain cure for morphinism. It is scarcely necessary to point out that to substitute heroin for morphia is about the same thing as replacing wine by brandy or whisky.

In England matters are perhaps worse still. The proprietors of quack medicines are not merely tolerated; a recent trial has shown that they can rely on the encouragement and protection of the law, and that it sometimes costs dear to examine too closely, or at any rate to criticise, the doings of unqualified empirics. It is for this reason that I do not specify more particularly the frauds I am alluding to. I will only say that whenever a drug cure advertised in the papers and magazines is recommended by the ministers of religion, they may almost surely be suspected of

interested complicity.

Many a needy clergyman only manages to make ends meet by receiving paying guests, and a well-known medical practitioner, who is at the same time a Justice of the Peace, gave me recently an amusing account of the tippling that goes on in the public-houses of his village amongst the ex-drunks resident in a certain rectory, and which is patent to all but the parson, who certifies regularly, no doubt in perfect good faith, to their salvation, and so obtains a constant succession of clients from the organisers of the cure with which he is associated.

MR BERNARD SHAW AMONG THE DOCTORS.

I am, Sir, yours truly, OSCAR JENNINGS.

Paris, February 24th, 1909.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. Sir,—It is never too late to mend; and it is pleasant to see that Mr. Bernard Shaw has come out with an address to doctors, on the whole good-natured, and "showing more pity than contempt for natured, and "snowing more pity than contempt for the unfortunate medical men who struggle to make a decent living in poor neighbourhoods." As one of the latter class, I am sorry Mr. Shaw did not begin earlier. I am sorry for the sake of the poor and am sorry for myself. Mr. Shaw, whatever he is now, was until lately an anti-vaccinator, an anti-vivisector, and an anti-bacteriologist. He was engaged actively in backing up the bands of fanatics who devote their lives to the depreciation of science and to the disparagement of its representatives in the medical pro-To what harm these things lead is only fession. known to practitioners among the poor. Distrust of the profession drives the simple and ignorant into the hands of quacks; leads them to rely upon fraudulent nostrums, and to spend £3,000,000 annually upon this trash. This does not hurt the practitioner from the sordid point of view. Of the numbers of people with maladies, aggravated or created by quackery, a vast number pass, sooner or later, into the hands of qualified men; and so money that would not otherwise be earned is put into their pockets. I have just seen a case in point. An old patient, suffering from habitual

constipation, easily controllable by simple methods, has been dosing himself for many months with one of the most largely advertised pills of the day. It is composed, as most of us know, of aloes, ginger, and soap; and is warranted to cure a score of distinct diseases, besides "indigestion." The aloes, in increase. diseases, besides indigestion. It alous, indigestions doses, having originated piles, has now led to formation of a rectal abscess and fistula. I am going to operate, and I shall get a fee of a few guineas entirely through the effect of quackery. Like every practitioner among the poor, I am constantly seeing cases in which life might have been indefinitely prolonged, but which have run on to a stage in which death is inevitable owing to reliance having been placed upon fraudulent nostrums of one kind or another. The people know nothing about the struc-ture of their bodies, and their education in medical matters is almost entirely derived from the puffs which fill the columns of the cheap newspaper press. They nii the columns of the cheap newspaper press. They look upon diseases, or the symptoms they mistake for disease, as distinct entities to be driven out of the body by specific antidotes. Poor patients are unwilling to submit to examination, to scientific investigation of their maladies. They demand "something to do them good," something "to cure" the complaint which they themselves have diagnosed and named with the aid of the quack advertisements which they have studied. The practitioner among the poor is dragged down in his practice to the level of his ignorant patients; often to the moral situation of the meanest of petty business men. It is within the power of Mr. Bernard Shaw to do at least something by his teachings to improve this state of things; let us hope that his new departure implies a promise to do so.

I am, Sir, yours truly,

A Poor Practitioner.

London, N., February 26th, 1909.

THE CENTRAL MIDWIVES BOARD AND SEPSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The explanations offered by Dr. Ward Cousins and "Obstetrician" do not seem to me to put the objectionable regulation of the Central Midwives Board in any better light. Neither of them deny that the best teaching of modern midwifery regards vaginal examinations as a source of danger. It is doubtful whether it is possible, as Dr. Ward Cousins suggests, for a woman to gain "by internal and external examinations a practical knowledge without any risk to the patients." At any rate, the net result is that pupil midwives will learn from the regulations enforced on them that they should make repeated vaginal examinations, and if they read Dr. Ward Cousins' letter they will further learn that they can do this "without any risk to her patients." Encouraged to get into habit of making vaginal examinations, they are not likely to give up the habit, when they cease to be pupils and become certified midwives. I am, Sir, yours truly,
PATHOLOGICAL.

INCONTINENCE OF URINE ASSOCIATED WITH EPISPADIAS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I regret that my attention has only recently been drawn to the kind letter of "A London Surgeon," which appeared in your issue of February 3rd. Otherwhich appeared in your issue of repruary 3rd. Otherwise I should have sent an earlier reply to his inquiries concerning my account of the operation in THE MEDICAL PRESS AND CIRCULAR for January 27th.

There was not "much difficulty in separating the neck of the bladder and the short urethra from the public bones, and from their lateral attachments."

By going slowly and keeping close to the pubic bones and to the lateral walls of the small pelvis, the risk of injuring the neck of the bladder and the muscular tissues at the side was avoided. I had to rest awhile until the free venous bleeding had been arrested by gauze packing.
As regards the unfortunate need for changing the

obstructed small catheter, after attempts to make it

pervious had failed, there was no great trouble in introducing another one.

The new rubber catheter was well stretched over a carefully moulded stilette, and passed immediately after the other catheter had been withdrawn. The shortness of the urethra made it easy to ascertain the exact direction, when the stilette was removed, and the catheter was thus allowed to resume its natural shape, the latter fitted comfortably.

I am, Sir, yours truly,

R. P. ROWLANDS.

Queen Anne Street.

OXYGEN IN SPORT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—There is no occasion for Mr. Oscar Jennings to write so brusque a letter. Twenty-five years ago W. George, the famous runner, and holder of the mile record, tried oxygen, a fact which I published six months ago, so soon as I learnt it from Mr. George. months ago, so soon as I learnt it from Mr. George. No doubt many others tried oxygen when it was first introduced. Mr. Jennings will find exact determinations of the pulse, blood pressure, respiratory volume, etc., in my papers, published in the Journal of Physiology, and he should not be so rash as to assert that observations made by me "are totally wanting in physiological control." I shall be glad to see the account of Mr. Jennings' observations, which, published as they were in a weekly journal, have either escaped or not received the attention of all those who have carried out fundamental researches on the respirahave carried out fundamental researches on the respiranave carried out fundamental researches on the respira-tion. I would point out that the sphygmograph is not an instrument which can be used to measure tension of the left heart, and that Mr. Jennings' explanation of the action of oxygen is wholly wrong. "It does not restore wind at once by rendering the lung adequate to the extraordinary demand on it." I am indifferent whether athletes use oxygen to break records or notbreaking records is a foolish pursuit, and not sport in the true sense. What I have ascertained is that oxygen inhalation affords a simple and powerful method of relieving the fatigue of the heart which follows extreme muscular effort, and that oxygen and exercise can be used as a valuable method of treatment. able method of mounts of truly,

I am, Sir, yours truly,

LEONARD HILL.

#### AN APPEAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I write to ask you to open a subscription list for Dr. William Winslow, who, having acted for 47 years as Dispensary Medical Officer of Gowna Dispensary District, County Cavan, Ireland, was compelled to resign in October last year, at the age of 69 years, owing to ill-health, chiefly the result of hard

The facts are as follows:-

The district is a large one, about 14 to 18 miles, with a lake in the centre, which makes it very hard to work. It consists mostly of bog land, and therefore, needless to say, yielded very little indeed in private fees, and mostly required two horses to work

it properly.
When Dr. Winslow was first appointed his salary was £80 a year, this was after a time raised to £100, and subsequently to £120. On this salary, plus £16 as M.O.H., and about £20 from vaccination and registration fees, he kept the two horses necessary to work the processor of work the practice, reared a family of ten children and work the practice, reared a raminy of ten children and gave them a sound education. It should also be remembered that it is only during the last few years that Dispensary Medical Officers were allowed fees for a locum while on their holiday.

Dr. Winslow's willing readiness at any hour of the day or night to answer the calls of those who required him was proverbial throughout the entire district.

Last spring he contracted influenza, followed by heart trouble, and although after a sick-leave rest he made every attempt to continue to work the district in which he had spent his life and energies, he was compelled to resign.

Let me add that during all these years there never was any question that Dr. Winslow had done his

work other than to the perfect satisfaction of the Guardians.

Now note what happened: this district is under the control of the Granard Board of Guardians; this body duly met and awarded a pension of £80 a year. It appears the maximum they could have allowed is some £92 odd. The Local Government Board, who seemed wishful that the full superannuation should be granted, wrote to the Guardians and pointed out that at the passing of the 1898 Local Government Act, Dr. Winslow was 60 years of age, and entitled to look for a pension then, and asked them to reconsider their decision. This the Guardians refused to do. The Local Government Board then raised some technical point to the effect that sufficient notice had not been given and requested the Guardians to bring the matter up again. This the Guardians had to do, and meeting on February 15th, reduced the superannuation of £80, to which they had already agreed, to £60!

Although the resignation took place last October, no

pension money has been received yet. This has been a source of great worry to him. On this £60 Dr. Winslow has to keep himself (an invalid), his wife, and one unmaried daughter. All his other children, with the exception of one, who fell in the South African War, have heavy financial responsibilities of their own; all have families except one, and one is a

widow with three children.

Surely it is not the wish of the Profession generally that one of its members, after so many years of hard and good work, should, through the ignorance or ingratitude of those whom he faithfully served, and through no fault of his own, be left in old age and enfeebled health to drag out the closing scene of his life in anxiety and want.

I appeal, therefore, to the Profession, and especially to Irish medical men, who understand perhaps better than others the injustice and the hardships of the Irish Poor-law medical system, to subscribe to a fund for his benefit, crossing cheques, "Winslow Fund," and making them payable to:

Yours faithfully,

ARTHUR GREENE, M.A., M.D., F.R.C.S.I.

4, Theatre Street, Norwich, Feb. 20th, 1909.

[We shall be glad to give any assistance in our power to any movement to help Dr. Winslow in this case. We would, however, suggest to Dr. Greene that he should form a small committee of men whose names would carry weight both in England and Ireland, as by so doing he would probably collect more money. We also suggest that he should bring the case to the notice of the Irish Medical Association, of which we understand Dr. Winslow has been a member for many vears.—ED.]

#### SCHOOL DISINFECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I should be glad if you would allow me space for comment on a portion of a paper by Dr H. Meredith Richards, Medical Officer of Health for

( roydon, which appeared in a recent issue of a medical

contemporary.

Dealing with the subject of disinfection, Dr. Richards says:—"I sincerely hope that medical inspectors will not play into the hands of the wily manufacturer of germicides by suggesting the disinfection of premises when the bacteriological examination of a class or the exclusion of individual children is really indicated. Nor, I trust, will they vaunt the success of their favourite germicide in stamping out an epidemic which has already attacked the whole of the susceptible population exposed to infection."

The only inference to be drawn from these remarks is that the routine disinfection of schools, which of recent years has been urged in many quarters, is in reality a trade device for the sale of particular germisides. If Dr. Richards is in possession of information which warrants such an implication, he is, of course, perfectly justified in warning his brother officials; but, in the absence of such information, I should like to remind him that the mere fact that the principle of disinfection is advocated by manufacturers of disinfectants is not in itself sufficient to prove that the process is of no value as an aid to the prevention of

epidemic disease in elementary schools.

A paper by Dr. A. D. Edwards, Medical Officer of A paper by Dr. A. D. Edwards, Medical Officer of Schools, Bournemouth, which appeared in the *British Medical Journal* of February 13th, provides a striking commentary on Dr. Richards' contention that disease is spread by infected persons rather than by infected things. Dr. Edwards states that he collected all the slate pencils of a class in one of the schools, "made stroke cultures in a few tubes and the schools of the schools." stroke cultures in a few tubes, and the borough bacteriologist reported the presence of the Klebs-Loeffler bacillus in the growth." Among other preventive measures Dr. Edwards recommends the routine disinfection of the schools.

It seems scarcely probable that various medical men and public bodies have combined to "play into the hands of the wily manufacturer of germicides"; the more likely explanation of their advocacy of disinfection is that they recognise in it a practical preventive measure. No one, I should imagine, has ever contended that disinfection of the elementary schools, of itself, would prove sufficient to eradicate infectious disease. That there is much to be said in its favour, however, is shown by the expressed opinions of the authorities I have quoted, and in view of the fact that the measures at present at the disposal of the authorities have not achieved any marked diminution of school epidemics, it seems to me personally that hostility to the systematic use of disinfection is unwise and inimical to the interests of the community.

I am, Sir, yours truly, J. T. AINSLIE WALKER.

February 28th, 1909.

#### OBITUARY.

CHARLES ROUTH, M.D.LOND., M.R.C.P.LOND.

WE regret to announce the death of Dr. Charles

WE regret to announce the death of Dr. Charles Henry Felix Routh on the arst ult., at his residence in Montagu Square, London, W., at the age of 87. Dr. Routh was the eldest surviving son of Commissary-General Sir Randolph Routh. In 1843 he became a member of the Royal College of Surgeons, whilst a year later he took the M.B. and in 1845 the M.D. degrees of London University. He was also a member of the Royal College of Physicians. He received his medical education at University College Hospital, Paris, and Vienna. Dr. Routh held many appointments, including Consulting Physician for Diseases of Women at the North London Hospital, the Consump-Women at the North London Hospital, the Consumption and Samaritan Hospitals, and the Cripples Homes for boys and girls. He was a Physician at St. Pancras Royal Dispensary, and a corresponding Fellow of both the Royal Academy of Madrid and the Academy of Pesth.

For over half a century he contributed articles on infant feeding, cancer, and other subjects to the London medical journals, the *British Gynacological Journal*, and other publications. Dr. Amand J. McC. Routh, Obstetric Physician to Charing Cross Hospital, is his son.

### DR, ROBERT HENRY COALL, L.R.C.S., L.R.C.P, Edin.

L.R.C.P.EDIN.

By a sad coincidence, this gentleman died at Cannes on his 50th birthday. Son of the late Talbot Coall, of Kingstown, Co. Dublin, he was born on February 20th, 1859, his death occurring on February 20th, 1909. He was engaged for some years past in a somewhat extensive practice in Brook Street, London, but latterly developed tuberculosis, and was residing for the time being at Cannes, where his health improved so much that a few days before his death he was making preparations to return to London from was making preparations to return to London from the Riviera, when an acute attack of hæmoptysis supervened, to which he succumbed, as before stated. on the 20th ult. Deceased was medically educated at Carmichael School, Dublin, whence he took the double qualification of Edinburgh in 1884. He was unmarried, but his genial character and happy dispo-sition endeared him to all with whom he was brought

in contact, and at his funeral at Cannes on Thursday last many leading members of the English community followed him to his last resting-place.

SIR JOHN WATT REID, K.C.B., M.D., LL.D.

WE regret to record the death of Sir John Watt Reid, at the age of 86. He was honorary physician

to the King and to Queen Victoria

Sir John Reid was the son of Dr. John Watt Reid, R.N., and entered the Royal Navy in 1845. In 1880 he became Director-General of the Medical Department of the Navy, which post he held until 1888, when he retired. He served in the Russian war in the Black Sea, 1854-55; in the China war, 1857-59; and in the Sea, 1854-55; in the China war, 1857-59; and in the Ashanti campaign, 1874. For his services in the last-named campaign he was mentioned in despatches, promoted, and received the medal. He was made a K.C.B. in November, 1882.

Sir John Reid was educated at Edinburgh, and obtained the Doctor of Laws and Doctor of Medicine

degrees from the Universities of Edinburgh and Aberdeen respectively, and became a licentiate of the Royal College of Surgeons in 1844. He married, in 1863, Georgina, a daughter of Mr. C. S. Hill, of Halifax,

Nova Scotia.

#### REVIEWS OF BOOKS.

A SYSTEM OF SYPHILIS. (a)

A SYSTEM OF SYPHILIS. (a)

The second volume of this work contains: (1) "The Surgery of Syphilis," by D'Arcy Power; (2) "The Treatment of Syphilis," by Colonel F. J. Lambkin, R.A.M.C.; (3) "An Outbreak of Syphilis in a Virgin Soil," by Colonel F. J. Lambkin, R.A.M.C.; and (4) "Syphilis in Obstetrics," by Dr. W. J. Gow.

(1) Mr. D'Arcy Power in his first chapter gives a short, but very lucid and convincing historical account of the origin of syphilis in Europe, showing plainly that the disease was brought from America by Columbus, disseminated over Spain and Italy, carried to France by the troops of Charles VIII. after their sojourn in Naples, and finally brought to England by way of Bordeaux in 1497. He takes his readers on to the discovery of the spirochæta pallida, and theorises very ably on the connections between syphilis and cancer and syphilis and tuberculosis. The second chapter deals with syphilitic diseases of the bores, and does not teach us anything very new; in fact, we and does not teach us anything very new; in fact, we should have been pleased if the differential diagnosis between syphilitic and tuberculous diseases of the bones had been more elucidated. A similar remark also applies to the next chapter with reference to gonorrhoeal and syphilitic affections of joints. Some interesting points are here considered on Charcot's disease and on symmetrical serous synovitis. Syphilitic diseases of muscles, tendons, and bursæ and teeth are described shortly in the next two chapters. The following chapter dealing with the mouth and tongue is well worthy of careful perusal; leucoplakia of the tongue, especially, with its treatment is excellently explained, together with the fissures to which this disease often gives rise. In dealing with the rectum, Mr. D'Arcy Power confines himself to generalities in a subject which we should have thought would have given him an extensive scope for teaching, but he evidently will not trench on ground which is to be taken by others in future volumes of this work. In the chapter on the urethra and prostate, we are confronted again with the disadvantage of a multiplicity of authors writing for the same work, for Mr. Power, in authors writing for the same work, for Mr. Power, in speaking of chancres of the meatus, refers us back to their description in Vol. I., by Colonel Lambkin, which, on reference, consists of about eight lines; we should have thought Mr. Power could have given us many useful hints with reference to the difficulty of diagnosis of the innocent-looking sores met with in this citation. This is brought still more forcible to this situation. This is brought still more forcibly to

(a) "A System of Syphilis." Edited by D'Arcy Power, M.B., F.R.C.S., and J. Keogh Murphy, M.D., M.C., F.R.C.S. Vol. II. Pp. vill. and 387. Oxford University Press: H. Frowde. London: Hodder

our notice by the able words on the differential diagnosis between tuberculous, sarcomatous and syphilitic testicle given in the next chapter. All that is known on gummatous inflammation of the mammary gland and on syphilitic goftre is ably set forth. Mr. Power on syphilitic goftre is ably set forth. Mr. Power devotes eighty pages to a really admirable treatise on the treatment of syphilis. He explains the various methods, and sets forth the advantages and disadvantages of each in a scientific and unbiassed manner. vantages of each in a scientific and unbiassed manner.

(2) The next seventy pages are devoted to the same subject, but from the pen of Colonel Lambkin, who necessarily has to cover a good deal of the same ground as Mr. Power; Colonel Lambkin, however, shows a very decided leaning towards treatment by intra-muscular injections with the insoluble salts of mercury.

(3) Colonel Lambkin then gives a very instructive and interesting account of "An Outbreak of Syphilis in a Virgin Soil," culled from notes on syphilis in the Uganda Protectorate. It seems sad to syphilis in the Uganda Protectorate. It seems sad to chronicle that the causation of the outbreak, according to Colonel Lambkin, had a twofold origin: (1) "The introduction of Christianity and the consequent abandonment of polygamy and of the old restrictions of the old restrictions of the old restriction of the old restrictio on the liberty of the women." (2) "The abolition of the punishments formerly meted out among the tribes for all immoral offences committed by either sex. for all immoral offences committed by either sex." This last we may regard as due to the march of civilisation. (4) The last chapter of this volume consists of an excellent treatise on "Syphilis in Obstetrics," from the pen of Dr. W. J. Gow, who ably discusses the vexed questions of conceptional, infantile and neonatal syphilis, together with Colles' and Profeta's laws; he also gives a short and concise account of the morbid anatomy af the syphilitic fœtus, of its various organs and of the placenta. The illustrations, which are all placed together at the end of the book, are excellent; but we still cannot help thinking that it would be more but we still cannot help thinking that it would be more convenient to the reader if they were each inserted opposite the respective page in which reference is made to them.

#### DISEASES OF THE NOSE AND THROAT. (a)

THE third edition of this well-known manual has appeared, having undergone a thorough revision, while the general characteristics of the former editions have been adhered to. As will be remembered, the second edition appeared under the joint authorship of Dr. de Havilland Hall and Mr. Herbert Tilley, but for this edition Mr. Tilley alone is responsible.

A new feature in the book is one that appeals to the fancy of the reviewer. He refers to the short anatomical description of the nasal cavities and the

accessory sinuses which, with capital illustrations, gives a very clear idea of the parts dealt with. The general trend of the book is essentially practical, and we thus have presented to the majority of readers a book which will be found interesting to read and reliable for reference when in doubt or difficulty.

The operations are very clearly described, and with the help of such good ilustrations there is no difficulty in following the author's ideas. At the end there is a formulary of prescriptions which will be helpful. It may be stated that Mr. Tilley's manual is one of the best arranged works of its kind which we have read, and will amply repay those who read it.

#### Medical News in Brief.

Birmingham and Midland Counties Sanatorium.

THE Lord Mayor of Birmingham presided on February 24th at the annual meeting of the Birmingham and Midland Counties Sanatorium. In his speech he remarked that he could only say with regard to this particular Society that there was not one more worthy of the support and admiration of the whole city. Its operations were not as large as some, but its work was

<sup>(</sup>a) "Diseases of the Nose and Throat," By Herbert Tilley, B.S. Lond., F.R.C.S. Eng., Surgeon to the Ear and Throat Department, University College Hospital, &c. Five hundred and twenty-four pages, with 126 illustrations. London: H. K. Lewis. Price 14s.

extremely valuable, and he was perfectly sure that it would be very much missed if by any unfortunate chance it came to an untimely end. It was an old Society, and he regarded it very much as a model Society. It was started just at the right time, and when the idea of sanatoria was almost unknown. In recent years the precautions taken with regard to public health had had the effect of reducing illness of all kinds, and they might hope that this would go on extending in future, so that they need not look to the indefinite extension of hospitals and sanatoria. There was not the slightest chance of such institutions being abolished at any time, certainly not in our time, and while they were in existence it behoved us to keep them in a state of efficiency.

The Lord Mayor was elected President for the ensuing year.

The year, said the committee in their report, had been one of increased usefulness, the number of patients having been the largest in the history of the sanatorium, namely, 1,655, with an average stay of 17.8 days, as compared with 1,598 patients in 1907, with a similar average stay. The increase in the work of the institution had brought with it an increased expenditure, and although the general income had been well maintained as compared with former years, yet it was with regret the committee had to report an adverse balance upon the year's accounts of £170 11s. 6d. They earnestly appealed for a substantial increase in the number of annual subscribers to ensure that the effi-ciency of the institution should be in no degree impaired.

#### Serious Outbreak of Typhold Fever at Kirkburton.

A serious outbreak of typhoid fever has occurred at Kirkburton, near Huddersfield. On November 21st last an isolation hospital erected near the railway station was opened for the treatment of patients suffering from infectious diseases other than small-pox, and a resident of an adjacent township, who was suffering from or an adjacent township, who was suffering from typhoid fever, was taken to the hospital a few weeks ago. A fortnight ago another person residing in Foresters' Row, Kirkburton, which is situated at the foot of a steep hillside almost immediately below the hospital, was found to be suffering from typhoid, and was removed to the hospital. A couple of days later the disease appeared in houses at Zion Hill, near to and on the same level as Foresters' Row. Other cases subsequently occurred at Zion Hill, and the patients were removed to the hospital, until there were six Kirkburton patients all suffering from typhoid. A girl of 13 died in the hospital on Wednesday, and on February 25th two more patients were admitted. There is now no more accommodation for typhoid fever cases, and one patient is being treated at home.

#### The Middlesex Hespital.

THE claims of the Middlesex Hospital to increased financial assistance were enforced at the annual meeting of the Court of Governors held on February 25th, under the presidency of Mr. Pearce Gould, the Senior Surgeon.

Lord Cheylesmore, who moved the adoption of the report, called attention to the fact that the total number of in-patients treated in the past year was 4,313, being an increase of 395 on the figures for the previous year, while in the out-patient department the number of new patients relieved was greater by 1,627, the total being 49.224. But the financial position had never been so serious during the twenty years he had been connected with the institution. The great loss was in bequests. In the last three years the average receipts from this source had fallen by one-half, and he failed to understand why the hospital did not get more generous support. Dr. Pasteur seconded the motion: The Chairman said that all round there was evidence of increased activity and extended means of doing the proper work of a hospital, but a more general interest and financial support were lacking. The motion, which was agreed to, also included the acceptance of a report on the administration of the Cancer Charity, respecting which Dr. Lazarus-Barlow gave a brief account of the work done in the Cancer Research Laboratories since their opening in 1900. He is the director of these labora-

Referring to investigations upon heredity in cancer, he said that examination of the records of 8,000 cancer cases of which the hospital had notes showed that there was no evidence that the disease was inherited. From the point of view of life assurance and of allaying a general fear, this work was of great public utility. The annual reports issued from the laboratories were full of information that was valuable to workers on cancer, and the information was as reliable as he and his assistants could make it. One great difficulty he had to contend with was the natural impatience of the public at the slow rate of progress. But the cancer question was bound up with the laws of growth, and though growth of an infant to manhood had been known for untold years, yet practically nothing was known as to the laws that governed that growth. So with cancer.

#### Humidity and Ventilation in Cotton Weaving Sheds.

THE report of the Departmental Committee on Humidity and Ventilation in Cotton Weaving Sheds Humidity and Ventilation in Cotton Weaving Sheds was issued on February 26th as a Parliamentary paper. The Committee, which was appointed in November, 1907, consisted of Commander Sir Hamilton Freer-Smith, R.N. (chairman), Mr. Joseph Cross, Mr. Henry Higson, Mr. T. Roberts, Mr. D. J. Shackleton, M.P., Professor James Lorrain Smith, Mr. Wilkinson Hartley, and Mr. Fred Thomas. Mr. Duncan R. Wilson acted as secretary. The report is signed by all the members of the committee except Mr. Higson, who died before the inquiry was concluded. died before the inquiry was concluded.

After submitting 13 recommendations of a technical character, the committee state in conclusion:—
"It is anticipated by the committee that their recommendations in regard to the standard of ventilation will by some be considered retrograde. In their decision they have been influenced by the evidence of eminent physiologists and by the personal experiences of the vast number of operatives immediately concerned, and they are of opinion that, although it is desirable to approximate as nearly as possible to natural conditions, yet when trade exigencies do not permit of this, it is better to have a standard capable of doing much good rather than no standard at all. They have further borne in mind that the interests of one of our largest industries should be considered and that manufacturers should not be called upon to maintain ventilating plant at enormous expense, unless it can be clearly shown that this is necessary for the well-being of the workers. In certain branches of the textile trade alone has a standard of ventilation been fixed, and it is perfectly well known that throughout the country in indoor occupations, especially in winter, the standard now proposed is often enormously exceeded.'

#### Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society was held at 429 Strand, London, W.C., on 19th ult.

There were present: Dr. de Havilland-Hall, in the chair; Dr. M. Greenwood, Dr. J. Pickett, Dr. J. Brindley James, Dr. St. Clair B. Shadwell, Dr. W. A. Dingle, Dr. W. G. Dickinson, Dr. Frederick S. Palmer, Dr. J. W. Hunt, Mr. J. F. Colyer, Dr. W. Knowsley, Sibley, Mr. F. S. Edwards, Mr. Edward Bartlett, and Dr. J. B. Ball.

The presenting of the Society during the month of

The operations of the Society during the month of January have been unusually successful. The claims have been moderate in number and for the most part of short duration, and as more than one of the chronic cases have been removed by death, the sickness experienced has been under the expectations. It has been resolved that the next annual general meeting of the Society shall be held at the rooms of the or the Society shall be held at the rooms of the Medical Society of London, 11 Chandos Street, Cavendish Square, London, W., on Thursday, May 27th, at 4.30 p.m., and a very favourable report may be expected by the members.

Prospectuses and all further information on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society as Changest Land London.

and Accident Society, 33 Chancery Lane, London, W.C.

#### NOTICES TO CORRESPONDENTS. &c.

COMMESSIONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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PERPLEXED.—The "dark room"—that is to say, confining a patient suffering from some disease of the eye, or after an operation upon an eye, to a room from which the light is excluded, is a mediaval superstition, comparable to the horrors of the Inquisition—which the enlightenment of science has dispelled as being an unnecessary feature of the treatment.

#### SIR J. BATTY TUKE AND THE PAINTER.

SIR J. BATTY TUKE AND THE PAINTER.

SIR JOHN BATTY TUKE, the well-known member for Edinburgh and St. Andrews Universities, celebrated recently his seventy-third birthday. His speciality is, of course, mental disease, upon which he is one of the greatest English authorities. An amusing story is told of him in this connection which is often repeated in Edinburgh University direles. Sir John is director of a home for the insanc in Edinburgh, and upon one occasion when the woodwork of the home required repainting, he himself delivered the order to the master painter that the work should be carried out. He impressed upon him with great earnestness that the painter who should be sent to do the work must on no account enter into conversation with any of the inmates of the home. Upon the following day Sir John went to see how the work was progressing, and, seeing the workman busily engaged, he asked him casually how many costs of paint he had put on. His question was met with absolute silence. He repeated it a little more sharply. Still no answer was returned. Annoyed at this neglect, Sir John sllowed his indignation to express itself in suitable terms and with such effect that at last the workman turned. "Awa" wi' ye, ye delectious deevil!" he cried, "awa" wi' ye!" And then he added in a gentler tone, "But I'ms sorry for ye a' the same." And then, of course, Sir John Batty Tuke understood. And although the joke was against himself, he always gave high credit to the workman for the humanity he expressed.—"M.A.P."

#### Meetings of the Societies, Tectures, &c.

WEDNESDAY, MARCH 3RD.

ROYAL COLLEGE OF SCHEKONS OF ENGLAND (Lincoln's Inn Fields, W.C.).—5 p.m.: Prol. A. Keith: The Mechanism of Respiration in Man. (Hunterlan Lectures.)

ROYAL EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinios: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meschen); Bye (Mr. R. P. Brooks).

THURBDAY, MARCH 4TH

NORTH-EAST LONDON CLINICAL SOCIETY (Prince of Wales's Hospital, Tottenham, N.).—4.15 p.m. Clinical Cases.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchhedie Street, Edgware Road, W.).—8.30 p.m.: Discussion on the Early Diagnosis and Treatment of Cancer of the Stomach (opened by Dr. W. H. White and Mr. B. G. A. Moynihan).

ROSTORN SOCIETY (20, Hanover Square, W.).—8.15 p.m.: Mr. A. A. C. Swinton: Some Vacuum Tube Phenomens.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m.: Dr. R. T. Hewlett: Disinfection and Disinfectants. (Milroy Lectures.)

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FRIDAT, MARCH STR.

ROTAL SOCIETY OF MEDICINE (LARTHGOLOGICAL SECTION) (20, Hanover Square, W.).—5 p.m.: Cases, Specimens, etc.: Dr.

Lambert Lack: Telangicotasis with Bpistaxis. Mr. W. Stuart-Low: (1) Thyroid Tumour of the Tongue; (2) Case showing an Unusually Large and Long Tongue. Dr. Donelan: (1) Uvula with Growth on Left Side; (2) Right and Left Rectangular Chisels for Removing Nassl Wall of Maxillary Antrum.

ROYAL SOCIETY OF MEDICINE (SECTION OF AMERIKETICS) (20, Hanover Square, W.).—At 8.30 p.m.: Discussion: On the Treatment of Shock during Amesthesia (opened by Dr. Dudley Buxton).

Buxton).

ROTAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Fields, W.C.).—5 p.m.: Prof. A. Keith: The Mechanism of Respiration in Man. (Hunterian Lectures.)

NORTH-EAST LONDON POST GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical Lapatient (Dr. R. M. Leslie). 4.30 p.m.: Lecture: Mr. R. P. Brooks: Types of Keratitis, their Diagnosis and Treatment.

SATURDAY. MARCH 6798

ROTAL SOCIETY OF MEDICINE (OTOLOGICAL SECTION) (20, Han-over Square, W.).—10 a.m.: Paper: Mr. Sydney Scott: A Con-tribution to the Problem of Vertigo. Cases and Specimens-illustrating the subject of Vertigo can be shown at this meeting.

#### Appointments.

BARRETT, W. E., L.R.C.P. and S.Edin., Clinical Assistant to the Samaritan Free Hospital for Women.

Colter. Stanley, M.D., B.S.Lond., M.R.C.P.Lond., Honorary Medical Officer to the Royal Halifax Infirmary.

DENNE, Archibald, M.B., Ch.B., Clinical Assistant to the Samaritan Free Hospital for Women
Fritzer, Isidor, M.R.C.S., L.R.C.P., Clinical Assistant to the Samaritan Free Hospital for Women.

Holmes, Gordon, M.D., B.C., B.A.O.Dub., Assistant Physician to Out-patients at the National Hospital for the Paralysed and Epileptic.

Kinedon, J. R., M.R.C.S., L.R.C.P.Lond., Medical Officer of Health to the Lynn Town Council.

Murison, A. Locan, M.R.C.S., L.R.C.P.Lond., Assistant Surgeon to the Metropolitan Ear, Nose, and Throat Hospital.

POTTER, J. C., M.D.Edin., Surgeon to the Metropolitan Ear., Nose, and Throat Hospital

VENNING, J. A., M.B., B.C.Cantab, Clinical Assistant to the Samaritan Free Hospital for Women.

WILLIAMSON, GEORGE SCOTT, Pathologist to the West Riding Asylum, Wakefield.

#### Bacancies.

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a year as Medical Officer of Health with Vaccination and Registration fees. Applications to E. W. Flynn, Clerk of the Union. (See advt.)

County Borough of Tynemouth.—Medical Officer of Health. Salary, 2300 per annum. Applications to E. B. Sharpley, Town Clerk, Town Hall, Tynemouth.

West London Hospital, Hammersmith Road, W.—Pathologist. Salary, 2200 per annum. Applications to B. J. Gilbert, Secretary-Superintendent.

Argyle and Bute Asylum, Londgilphead.—Assistant Medical Officer. Salary, £160 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent. Surrey County Lunatic Asylum, Brookwood, near Woking.—Third Assistant Medical Officer. Salary, £170 per annum, with board, lodging, and leundry. Applications to the Medical Superintendent.

Carlow District Asylum.—Resident Medical Superintendent. Salary, £350 per annum, and allowances valued at £150 per annum. Applications to the Secretary. (See advt.)

Brixton Dispensary, Water Lane, S.W.—Resident Medical Officer. Salary, £150 per annum, with furnished apartments, attendance, coal and gas. Applications to W. Halliday, Secretary. County Borough of Croydon.—Croydon Borough Hospital.—Assistant Resident Medical Officer. Salary, £120 per annum, with board, lodging, and washing at the hospital. Applications to F. C. Lloyd, Town Clerk, Town Hall, Groydon.

#### Births.

BOTT.—On Feb. 28th, at 58 Cambridge Terrace, Hyde Park, London, the wife of Percival G. A. Bott M.B. Lond, F.R.C.S.Ed., of a soc. WILSON.—On Feb. 27th, at The Hollies, Lee Terrace, Blackbeath, the wife (née Mary Mein) of C. Edgar A. Wilson, B.A., M.B., B.Ch. Oxon, of a son.

#### Marriages.

COWAH—DRAPHR.—On Feb. 23rd, at the Parish Church, Comington, Captain James Cowan, R.A.M.C., youngest son of the late John Cowan, Dunadry, Co. Antrim, to Linda Margaret, only daughter of the late 1 homas Draper, Lymm, Cheshire.

#### Beaths.

Amenous.—On Fab. 27th, at Southgate Lodge, Devises, suddenly, of heart failure, Liout-Colonel John Ambrose, R.A.M.O., rethred, aged 83. Norman.—On February 20th, at Guernsey, Bertram, third son of Thomas Norman, M.D., of Orosby, in his 38th year.

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to H.M. the King

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## THE MEDICAL PRESS AND CIRCULAR

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, MARCH 10, 1909.

No. 10.

#### Notes and Comments.

Further Explanation Wanted.

In our correspondence columns we publish a letter from Dr. Charles Hayward, of Liverpool, with reference to our leading article of last week upon "Private Patients in Charitable

Hospitals." On the strength of a newspaper report we stated that "the chairman read from a circular sent to every applicant for attendance in the private ward." The opinion we gathered, presumably as anyone else attending the annual meeting or reading the newspaper report would have done, was that a check was kept on the class of patients concerned by a system of printed circulars. Dr. Hayward now writes that he has publicly challenged the chairman to state whether these regulations were not passed at the committee meeting immediately preceding the annual meeting, and he asks pointedly whether any such form of questions as that read out existed a month prior to the annual meeting. The answer conveyed through the secretary-superintendent, according to Dr. Hayward, while denying the implications, admitted they had been adopted by the committee five weeks before the annual meeting. If the state of things thus described be true, the practice referred to is hardly of the absolutely candid nature that we are entitled to expect in the handling of the affairs of a great Liverpool hospital. There may, of course, be an adequate explanation of the other side of the question. If so, it is to be hoped that the chairman will come forward in person to explain the exact facts connected with the circular letter read by him at the meeting.

It is sad to read in the Annual Report of the Medical Graduates' The Club and Polyclinic that that excel-Polyclinic. lent institution is in a bad way financially. Indeed, if it were not for the generosity of Sir Jonathan Hutchinson, it would have had to close its doors at the end of last year. Everybody knows that post-graduate teaching, so necessary and, until lately, so much neglected, owes more to Sir Jonathan than to any other man living, and it is hard that, after all the years of building up, the institution which he has created and brought to such a high pitch of efficiency should still be so far from self-supporting. It seems that not only had Sir Jonathan to forego the It seems interest on the College mortgage, which he had himself supplied—a matter of £224 a year—but also to find a £100 to prevent there being a deficiency on the year's working. On the other hand, the future seems to be a little brighter, as many mem-bers have increased their subscriptions, and remunerative work in the shape of analyses and reports is growing. For our own part, we can only

say that we should regard it as little less than a calamity if this unique institution were to perish from inanition, and we think it would be greatly to the discredit of the profession if it allowed things to come to such a pass.

Most " Peculiar." THE Peculiar People will have to look to their laurels, for there is a gentleman at Southend who seems likely to out-Herod Herod. Indeed,

he is so "peculiar" that he can find nobody to form a sect with him, and so he remains outside the camp of all religious denominations, but he resembles the Peculiar People, not only believing the Bible literally from cover to cover, but in practising the ordinance recommended by St. James in case of sickness. As he is the only member of the sect, it is obvious he cannot call in an elder to anoint his family when sick, but he remains a convinced faith-healer all the same. Last week he was before the Southend justices on a charge of neglecting to provide medical attendance for his daughter. The unfortunate child had dislocated her elbow, and beyond offering up prayers for her restoration, Mr. Olliver did nothing. The magistrates happily took a more practical view of the situation, fining the parent and ordering the child to hospital. This fanatic bases his trust in supernatural healing, on the fact that he suffered for many years from hernia, and after carefully studying the Bible the hernia disappeared, and he was able to change a bath-chair for a bicycle. We congratulate the Southend Bench on not allowing the painful experiment on his child to be unduly prolonged.

Salvation by Starvation.

In the days when fasting-men were the order of the day at the Aquarium and elsewhere, much controversy took place as to the physiological effects of that process on the organism, but there was a pretty general belief that

most of the "fasts" were such only for business purposes. At any rate, the subjects survived a series of forty days abstinence from food with remarkably little ill effect. In Berlin at present it is said that a Miss Clair de Serval, reputed to be the niece of "Dr." Tanner is submitting herself to a series of fasting experiments at the Charity Hospital. This young lady does not aim at the celebrity conferred by forty days starvation, but is content with ten and twenty days at a stretch. She lives in a glass cage into which air is pumped, and she communicates with a gluttonous world through the prosaic telephone. Miss de Serval asserts that her habits of abnegation have turned her from a neurotic into a healthy being, and that when her

fasts are over she feels like the eagle endowed with renewed youth. We cannot take any responsibility for the genuineness of the experiments, but if the facts as related are even approximately true, the researches of Chittenden and those of the "purinfree" enthusiasts will have to take a back seat in the future. أيذار

It must have been a considerable blow to America when M. and Thor-Rad-X. Madame Curie announced their discovery of radium, for, admittedly, this element has been the wonder of

the world, and not to have been the means of introducing anything big, or showy, or important, must be a very sad reflection to our ingenious and boastful fellow Anglo-Saxons. A little late in the day, but still sufficiently early to be of service to his generation, a Dr. Bailey, of Chicago, has discovered a substance like radium, but, needless to say, much cheaper, less harmful, and of infinitely greater utility. We have not yet heard particulars of the source of this new scientific marvel, but no doubt the anxiety of a wondering world will soon be satisfied by the inventor. At present this astonishing substance revels in the euphonious name of "Thor-Rad-X," and one of its first little feats has been to take a photograph through six inches of wood. After this we are not surprised to learn that among a few of the odd diseases which it will cure almost at sight are cancer, pleurisy, and locomotor ataxy. As "Thor-Rad-X" is said to be cheap, there is an excellent opportunity for some philanthropist to import a ton or two while Free Trade still exists to this country, and start an institute, which will not only relieve the congestion of our hospitals, but bring the healing rays from the dark places of Chicago into the suffering bodies of His Majesty's benighted subjects.

#### LEADING ARTICLES.

THE CHARITY OF THE PROFESSION .-- I. WE lately took the opportunity of quoting from the Sheffield Daily Telegraph some very commonsense remarks on the criticisms passed on medical men for not obeying instanter the calls of midwives to maternity cases. Unlike most journals, our contemporary took the reasonable view that a medical man does not go into practice in a poor neighbourhood for the fun of the thing, but in order to make a living for himself and family. As Mr. Bernard Shaw has lately told us, a medical man is a tradesman who sells advice, and naturally expects that advice to be paid for, as the butcher does his joints or the baker his loaves. Without committing ourselves entirely to that view-which is a little cynical, like most things Mr. Bernard Shaw saysit is obvious that the medical man is as much entitled to see a reasonable prospect of payment for his services before he accords them as is any other worker. In bankruptcy cases the presiding officer not infrequently tells creditors that they are deserving of little sympathy for trusting a man of whose financial position they know little; and yet the medical man is supposed by the public to trust people from whom he knows almost certainly he will never get payment. A medical practitioner in Sheffield has handed to the Telegraph an abstract of his bad debts for five years, certified by a chartered accountant in the city. From this it appears that this gentleman has in that period attended 1,191 persons, whose total fees at ordinary rates amount to no less than £1,260 15s. 11d.—not one penny of which will he ever see! Some of the bills included are for is, and is, 6d.; the highest is only £14. Moreover, in the bulk of these cases medicine was supplied, together, of course, with bottles, corks, pill-boxes, etc., etc. To say nothing of shoe-leather, carriage-hire, and wear and tear, the actual out-of-pocket expenses amount to no inconsiderable sum, and when to that is added the debt for the time and skill expended, we may reckon the £1,260 as the very minimum which the doctor has suffered. This gentleman, then, is dispensing charity at the rate of £250 a year, not, be it marked, on those people and for those ends which he would wish, but probably on a number of worthless creatures who regard him with deadly enmity because they have not paid him. Is this an exceptional case? We venture to hope that it is, that is to say, that the proportion of bad debts here disclosed is somewhat higher than the normal, but we do not think, from what we know of practices in poor neighbourhoods, that it is much out of the way. The gentleman in question does not give his total income, so that it is not possible to say what proportion the bad debts bear to the whole. But suppose we place his earnings at the handsome figure of £1,000 a year, he will be found to be giving away one-fifth to charity, besides any donations that he may give away of his own free will. It used to be reckoned by Mr. Gladstone that a man should set aside a tenth of his income for charity, and we fancy most people would agree that this was a generous proportion. But here we have a gentleman who nolens volens has to part with twice that sum. Will these hard figures strike the imagination of the hard-headed Yorkshireman as representing a little of the benefits which their community derive from the hard work and generous instincts of the medical profession, and will they be inclined, we wonder, to do something for those toil-worn doctors and impecunious widows who, after a life of harassing care, find themselves in their old age dependent on the painfully inadequate charitable contributions of medical men? We wish we could flatter ourselves that they would, but it is a notorious fact that the benevolent agencies of the profession never receive a farthing from the general public. It is universally assumed that because medical men live in decentlooking houses and keep up an appearance of bien-être, that there is always something behind it. How little true this is a search through a few bank ledgers would soon demonstrate. The medical man, theoretically, has to put all his goods in the shopwindow and keep them there. It is his only chance of attracting a clientèle who will pay their bills. It is easy, of course, to write, as we are doing, in a professional journal, but, after all, we are only, so to speak, preaching to the converted. If papers of the power and influence of the Sheffield Daily Telegraph could see their way to keeping this matter of the charity of the profession, ill-requited as it is, in the public eye, a great deal of substantial benefit might accrue, not in the way of making people more honest, but of making them more appreciative of what is done for mankind by medical men who can ill afford it, and—who knows? perhaps even the benevolent agencies of the profession might receive substantial donations.

## THE ADMINISTRATIVE MEASURES AGAINST TUBERCULOSIS.

A SHORT but important paper has been recently issued by the Medical Officer of the Local Government Board. It consists of a memorandum of thirteen pages, in which Dr. Newsholme supplements the circular letter sent by the Board with the Public Health (Tuberculosis) 1908 Regulations to all Sanitary Authorities and Boards of Guardians. Its general scope is set forth in the preamble thus: - "The prevention of tuberculosis and the aid which can be given to patients suffering from it depends in large measure on knowledge of its pathology," and the earlier part of this memorandum deals briefly with this aspect of the Afterwards are set forth the chief adquestion. ministrative measures that can be taken against the disease, and the different forms of aid that can be given to the patient, either through administrative or voluntary agencies. The memorandum extends the campaign against tuberculosis beyond the limits of the Poor-law, so as to include a great mass of poor patients other than those in receipt of relief within the remedial measures rendered available by the co-operation of local authorities and voluntary charities. Another point that should be borne in mind is that the memorandum deals with human inspection alone, with the somewhat dog-matic explanation that "this is chiefly responsible for the causation of pulmonary tuberculosis." The body of the document under notice is devoted to a consideration of the measures which may be utilised against tuberculosis. These may be said broadly to depend on the facts, first, that the disease is caused by a specific pathogenic micro-organism, and, secondly, that it is preventable by hygienic measures that, to be successful, must be administered both collectively by State and other administrative organisations, and individually by the enlightened citizen. In point of fact, the matter stands very much now as it did in the earlier days that followed the famous discovery of Koch; the education of the public and of the individual is absolutely essential. This view is well put by Dr. Newsholme in the proposition that tuberculosis is much more a disease of ignorance than one of misery, as it has often been described, and that many of the measures for its treatment and relief. if properly employed, have amongst their most valuable results the hygienic training of the patient. He enlarges upon the importance of teaching hygiene in school life, and remarks that much more could be done in this direction by special instruction of various social groups, trade unions, friendly societies, and so on, as well as in the Army and Navy. Needless to add, instruction of the tuberculous patient and of his friends is absolutely essential for the prevention of tuberculosis. This can be attained by health visitors, and by disinfection and other special measures devised by local authorities. Any efficient public system, however, must have some machinery of notification and some means whereby early diagnosis is rendered

possible on the part of medical practitioners. So far as the voluntary medical charities are concerned, their most important rôle, after all said and done, is probably educational. Their best curative work is effected by placing the patient under an advantageous environment rather than by drugs. In this respect a great deal may be said in favour of the tuberculosis dispensary, where special attention is given to the early diagnosis of disease. The payment of a notification fee to the medical attendant is properly advocated. As regards the, sanatorium, its value is emphasised in the early and the terminal stages of the malady. In the former it is useful mainly as an educative experience to the patient, and in the latter as removing from a private household an active centre of infection to a specially-regulated environment in which the primary preventive measures of disinfection and isolation are imposed. The whole problem. must necessarily be treated in accordance with local needs and local possibilities. "The best work," says the memorandum, "will be secured if there is active co-operation between voluntary and official workers and agencies, and this remark applies particularly in securing sanatorium treatment for patients." If all the measures within the range of practical action are adopted, there is no reason to doubt that by wise administrative effort following upon the Board's Regulations as to Tuberculosis, the decline in the number of centres of infection can be made more rapid, and thus can be secured a quicker decline in the death-rate from tuberoulosis than has hitherto been experienced. Although, owing to the long duration and occasionally the long latency of this desease, results in regard to it cannot be measured with accuracy except after the lapse of a considerable number of years, it may confidently be expected that administrative measures will enable sanitary authorities gradually to bring tuberculosis within their control, and to secure that it shall become as much a disease of the past in this country as leprosy has become." In conclusion, the attention of readers who are interested in the important question may be specially directed to this official memorandum, which may be purchased for a few pence from the official printers.

#### CURRENT TOPICS.

#### Overcrowding in the Profession.

In spite of the many complaints as to the difficulty of making a fair livelihood in the medical profession, the number of medical men in the Kingdom increases year by year, and the number of entries to the medical schools also increases. It has been calculated that the average income of the medical practitioner is somewhat between £200 and £300 a year, and this is certainly a poor return for an education costing probably £1,000. Moreover, many sources of income are gradually disappearing with the diminishing prevalence of the infective fevers. It is true that new careers for medical men are appearing in these days, such as those of medical officers of health, school inspectors, and so on, but most posts of the sort are poorly paid, and do not tend to raise the average income to any appreciable extent. Under these circumstances, it has seemed wise to many medical men in authority to warn lads who are about to choose their profession against entertaining too rosy views of a medical career. The Manchester and Salford Divisions of the British Medical Association have gone a step further, and have addressed a letter to the headmasters of all the public schools and grammar schools in Lancashire, directing their attention to the conditions we have mentioned, and asking them to make the facts known to boys who think of entering the profession.

#### A Tidal Wave of Influenza.

FOR years past influenza, that most evasive but relentless of epidemics, has ebbed and flowed in monotonous fashion. During the present year, however, it has suddenly swept the United Kingdom with the disastrous force and suddenness of a great tidal wave. Probably at no previous time of its history has this pest been more universal and more disastrous. Last week a large number of deaths were attributed directly to influenza, which has invaded all ranks of society with the wellknown impartiality which characterises this malady. One well-known authority on mental diseases has drawn attention to a fact that has long been recognised in conncetion with influenza, namely, its tendency to lead to melancholia and insanity. It is well that the public should be informed upon this point, so that due allowance may be made for any eccentricities of temper or of conduct on the part of patients, and a careful watch kept upon their If persons who get "bad colds" could only be induced to lie in bed and keep quiet for a few days there would be practically little or no risk of influenza becoming complicated with heart failure and lung inflammations, and the nerve affections that now constitute its chief dangers. But will mankind ever be wise enough in the mass to go to bed and send for the doctor for its minor ailments? Imagination fails to estimate the number of generations of school-board education it will require to evolve such an acme of national wisdom. About that period, also, the disappearance of the last quack nostrum may be anticipated.

#### The Meaning of the word "Sanious."

It is curious to note what entirely different meanings are given to the word "sanious" by different writers. So much is this the case that the true meaning of the word is rapidly being lost. attention has been drawn to this on numerous occasions, and on each of these the user of the word was as confident that he had used it in its correct sense as he was of his use of any other ordinary term. A typical instance of the perverted use of the term is to be found in the current issue of a contemporary, where a writer refers to the fact that, whereas one author is "sceptical as to the existence of real tears of blood," another admits that "in certain circumstances the lachrymal gland secretes a sanious fluid." Here it is obvious that the word is used as a synonym for "sanguineous," and as most medical men are inclined to use it in this sense, it is worth while trying to find its correct meaning. The word is derived from sanies, which is described in the dictionary as being "akin" to sanguis, but which was used by Propertius to signify "diseased or corrupted blood," "bloody matter," and metaphorically in Virgil and Horace of the "slaver" of a serpent. From this word is derived the French sanie, which means "matière purulente, qui sort des ulcères et des plaies non From it also comes the word under soignées." discussion, "sanious," which is defined in Johnson's dictionary as meaning "running a thin serous matter, not a well-digested pus." This definition is practically identical with that given in the present-day medical dictionaries, namely, "of the nature of a fœtid ichorous discharge, containing serum, pus and blood." In spite of the universality of this definition, nine out of every ten medical men will, if asked, say that sanious means bloody, and will use it in exactly the same manner as the writer we referred to above.

Pay Wards in General Hospitals.

A discussion has arisen, somewhat acrimonious in tone, in the Liverpool press, as to the question of the admission of paying patients to general hospitals, and their relation to the visiting staff. It appears that it is the custom of the Royal Southern Hospital to admit paying patients to certain wards at a charge of two guineas a week, the surgeon or physician in attendance giving his services for nothing. It is alleged by those who object to this system that persons are admitted to these wards who are not only able, but willing to pay surgical or medical fees. If this be so-and it would be difficult to think the contrary-then two evils are inflicted by the charities in question. In the first place, the charity robs the general medical men of the city of their legitimate opportunity of earning fees, and, in the second, it does so at the expense of its own honorary staff. We believe that in a city such as Liverpool there can hardly be much real need for pay wards in general hospitals, but if there be, then the medical staff should be allowed to take fees for the work done.

## Home Nursing of Pulmonary Tuberculosis in Dublin.

ONE of the most beneficent activities undertaken as yet by the Women's National Health Association of Ireland is that of the home nursing of persons suffering from pulmonary tuberculosis. Some twelve months ago a scheme was inaugurated by which patients attending the out-patient departments of the Dublin hospitals, who were suffering from phthisis, could, if they chose, ask for and obtain the services of a nurse in their own homes. Two specially-trained Queen's nurses were employed by the Association, and the report of their first year's work has just been issued. It is evident that the nurses have not been idle, and also that their services have been appreciated by the poor. In all, during the year, 7,087 visits were paid, and the work of the nurses kept increasing. In addition to giving the requisite nursing attendance, the visitors gave hygienic advice to the patients and their friends, and were instrumental in many cases in having patients sent to hospitals and sanatoria, or to the country. In addition, they distributed sputum flasks, disinfected rooms, distributed food, paid rent, and found homes for orphan children or for children whose mothers were in hospital.

In fact, they seemed to have acted like the good Samaritan in every way possible. We heartily congratulate the Women's National Health Association on the record of work done. We do so with all the more pleasure in that, while the co-operation and active help of the physicians of the Dublin hospitals was given, their services were not unduly exploited, as has been done in some of the other activities of the Association.

#### The Metropolitan Asylums Board Finance

THE fact that an immense amount of good work has been achieved by the Metropolitan Asylums Board must be generally admitted. The warmest admirers of that body, however, could hardly venture to contradict the fact that the expenditure of the Board is often on a lavish scale. The recent annual statement on its finances dealt with large figures, and it is comforting to note that the outgoings showed a reduction of £133,000 on the average of five previous years. The total gross expenditure was £1,116,000. The cheerfulness of ratepayers will hardly be raised to an exuberant pitch by the state of affairs at the Joyce Green Hospital for small-pox, to which Mr. Spender very properly drew attention. It seems that the institution in question costs £20,000 annually to maintain, and during the past two years it has received only one patient. The total sum of £40,000 has therefore been drawn from the pockets of the ratepayers, in order to tend a single person suffering from small-pox. The superintendent, it was stated, draws £700 a year. That there should be small-pox accommodation available in the metropolis is evident, but that it should be provided and maintained at this rate of wanton extravagance is explicable only upon the ground that the Metropolitan Asylums Board, not being a directly elected body, can afford to disregard the monetary interests of the ratepayers. It is to be hoped that the Local Government Board or some central controlling authority will induce the Asylums Board to devise some scheme whereby the wards of Jovce Green Hospital may at once be put to some useful purpose, instead of lying vacant for the epidemic of small-pox that may possibly never again invade London.

#### PERSONAL.

It is announced that Surgeon-General George Bourke, C.B., has been appointed Hon. Physician to the King, in succession to the late Surgeon-General T. Tarrant, C.B.

DIRECTOR-GENERAL SIR ALFRED KEOGH, K.C.B., is to be made the recipient of the Honorary Degree of LL.D. at Edinburgh University.

LORD ASHBOURNE will be the guest of the evening at the Annual Dinner of the Irish Medical Schools' and Graduates' Association, to be held at the Hotel Cecil on March 18th.

THE LORD MAYOR has promised to take the chair at the 81st Annual Meeting of the Royal Free Hospital, to be held at the Mansion House this afternoon, when a special appeal will be made for funds. Dr. Prosper Liston received a handsome testimonial on leaving Penryn, he having accepted a Government appointment at Penang, in the Straits Settlements.

SIR VICTOR HORSLEY has been appointed Linacre Lecturer at St. John's College, Cambridge. His lecture, to be delivered on May 6th, will have as its subject, "The Motor Area of the Brain."

DR. C. R. CLARK, Physician to the Toronto Hospital for the Insane, has been appointed Dean of the Medical Faculty of the University of Toronto in succession to R. A. Reeve, whose name is well-known in this country.

AT a recent meeting of the General Court of Governors of Guy's Hospital, the vacancy on the Obstetric staff of the hospital, caused by the resignation, a few weeks since, of the late Dr. Peter Horrocks, was filled by the appointment thereto of Mr. Guy Bellingham Smith, M.B., F.R.C.S.

THE Council of the University of Liverpool, at their last meeting agreed to establish a Profesorship of Forensic Medicine in the University, and appointed to the Chair Dr. R. J. M. Buchanan, who has held a lectureship in the subject in the University for the last three years. Professor Buchanan is a recognised authority on his subject, as is shown by his published work.

THE Gold Medal founded by the late Sir Gilbert Blane, Bart., to be given biennially, has been awarded by the Medical Director-General of the Navy and the Presidents of the Royal Colleges of Physicians and of Surgeons to Staff-Surgeon Charles R. Nicholson, for his Journal of H.M.S. Egmont, November 6th, 1906—December 31st, 1907, and to Staff-Surgeon Arthur W. B. Livesay, M.B., for his Journal of H.M.S. Bonaventure, April 2nd—December 31st, 1907.

Professor Galt, Dean of the Medical Faculty of St. Mungo's College, Glasgow, has been appointed to the post of Pathologist to the Stephen Ralli Memorial Laboratory at the Sussex County Hospital, Brighton. During the eleven years since his appointment to St. Mungo's College, Professor Galt has done good service, and as a teacher he has been greatly appreciated by many students, perhaps more especially by those who took their post-graduate studies in Public Health work under him.

At Southport on March 1st the Mayor presented to Dr. John Hargreaves Robinson a gold watch, awarded by the German Emperor in recognition of his services in helping to rescue the crew of the German steamship Nord See, of Lubeck, which was sunk between Hull and Hamburg last May by collision with the Avoca.

The watch is emblazoned with the German Imperial crown, and bears the Kaiser's initial, and it was accompanied by a letter of thanks from the German Government. For helping in the work of rescue and afterwards professionally attending those of the crew of the Nord See who had been submerged Dr. Robinson also received the Hamburgische ferein Seefahrt medal. Dr. Robinson last week was appointed Surgeon of the Western Telegraph Company's cableship Norseman, at present stationed on the East Coast of South America.

#### A CLINICAL LECTURE

ON

#### THE PRESENT POSITION OF INTRAVENOUS TREATMENT.

By FELIX MENDEL, M.D.,

Essen (Ruhr).

[SPECIALLY REPORTED FOR THIS JOURNAL.]

PART II.

A NEW and very promising era for treatment by intravenous injection by atoxyl has quite lately been opened up in the employment of the method in the treatment of protozoal diseases, trypanosomiasis,

syphilis and malaria.

If, in spite of the great services of Koch in combating sleeping sickness by means of the subcutaneous injection of atoxyl, the success desired has not been attained, the cause has been that, notwithstanding the enormous dose, it has not been possible to establish the necessary concentration of the remedy in the blood fluids that seem to be required to kill off the protozoa at a stroke, and so in "one act to effect a sterilisation of the infected organism" such as Ehrlich desired to accomplish. Insufficient repeated doses, instead of destroying them, make them firm against the atoxyl (atoxylfest), and in this way the only known specific remedy is perfectly inert.

Even if a high dose bordering on intoxication were used by subcutaneous injection, sterilisation would still not be attained, as with the slow absorption of the remedy from the connective tissues, and its gradual passage into the blood channels in small quantities, the excretion from the kidneys would keep equal pace with it; with intravenous injection the arsenic reaches the blood current in full dose and in the highest degree of concentration, and leaves them rather more slowly than medicines that reach them by way of absorption in divided doses. Therefore, if possible at all, the intravenous injection of arsenic is alone in a position to effect "sterilisation in one act" required by Ehrlich, and to bring about the definite cure of sleeping sickness.

With the treatment of syphilis and parasyphilis by large doses of atoxyl, as Salmon and many German authors recommend, I have met with nothing but failures, indifferently whether the atoxyl were given subcutaneously or into the veins. On the other hand,

failures, indifferently whether the atoxyl were given subcutaneously or into the veins. On the other hand, the administration of small doses gradually increased—0.05 to 0.15—has shown in these diseases also that atoxyl, especially when used in the thoroughly effective and yet sparing manner into the vein, that it belongs to that class of highly important remedies that have

to that class of highly important remedies that have a favourable influence on the nutritive processes, and heighten the resisting power of the organism.

By means of intravenous injections of quinine, Baccelli has been able to save serious cases of malaria, cases apparently doomed to death. Atoxyl has proved its value in this form of protozoal disease when injected subcutaneously. Why should not atoxyl, just as well and perhaps better than quinine, have its curative action against malaria heightened when given by way of intravenous injection? The correctness of this assumption I can prove, it is true, only by one grave case of malaria that had been refractory to quinine, and only recovered after injection of 1.5 grm. of atoxyl given in 5 individual doses. Wider experiences must show whether, in intravenous treatment by atoxyl, we have a further remedy against malaria equal to quinine, and perhaps in many cases superior to it.

(4) Intravenous Treatment by Salicylates (F. Mendel). In order to avoid the disagreeable by-effects of the salicylates on the intestinal tract, and which rarely fail to be present, and at the same time attain the highest effect with the smallest possible dose, the intravenous injection of small doses of salicylate of soda was recommended by me, and especially as the subcutaneous employment of it was out of the question owing to the great pain it caused.

The most active and the most suitable for use was a 20 per cent. solution of sodium salicylate, the injection of which, with the addition of caffein, is perfectly painless and free from irritating effects:

R Natrii salicylici, 8.o.
 Caffeini natrii salicylici, 20.o.
 Aq. destillatæ, ad. 5o.

Or,

Natrii salicylici, 8.75. Caffeini, 1.25. Aq. destillatæ, ad. 50.

These solutions, at first clear as water, become coloured when exposed to light and air; they become reddish-grey or brown, and their reaction also changes, and these are changes that are not absolutely irrelevant as far as intravenous injection is concerned. For an injection fluid so changed may set up thromboses and cause rigors, whilst these disagreeable byeffects are excluded with some degree of certainty by the use of unchanged solutions. For this reason an advance not to be undervalued as regards intravenous therapeutics is the introduction of a solution prepared according to my directions in ampullæ by the Vereinigten chemischen Werke in Charlottenburg, under the name of attritin, and furnished at a reasonable price.

Intravenous treatment by attritin injected once or twice a day according to requirements, has, from our experience, but little vasomotor, and with it antifebrile, action, whilst its antitoxic effect on the pain and swelling of the joints must be called quite remarkable. In febrile rheumatic affections we must bring the internal use of the salicylates into the field first, and if from any cause this fails, we can replace it by intravenous injection, which then from its great antitoxic action is often followed by brilliant results. For the reasons stated, the afebrile rheumatic affections will always be the special domain for the employment of attritin by intravenous injection, and here this method of using the salicylates will, in spite of the small dose, from the high degree of concentration of the drug on its entrance into the blood current and its slow elimination, often bring about positively striking symptomatic and even curative results.

Troupel, who has collected the results of an extensive employment of the salicylates, has made use of it by the vein and with success in chronic articular rheumatism, whether chronic deforming arthritis on arthritis ankylopoietica following acute rheumatism. It is in just these incurable forms that "salicylic treatment, especially in the form of intravenous injection of F. Mendel, Essen, has done the best service in combating the pains often so crippling and hard to bear."

(5) The Intravenous Employment of Digitalis (Kottmann, Mendel, Fraenkel).

The possibility of introducing digitalis substances directly into the blood current without local or general mischief is very important for those cases in which threatening conditions demand speedy interference, or in which internal treatment seems to have lost its effect, or, from whatever cause, no effect has been produced. Intravenous treatment is of special value in such cases, as it puts us in a position of being able to avoid those rocks on to which digitalis treatment, however carefully carried out, not unfrequently casts us. It allows the possibility of accurate dosage—i.e., the precise determination of the quantity of the medicine entering the blood current and there coming into action, which in the case of internal or subcutaneous

administration depends, and especially in pathological conditions, on very varying and incalculable conditions as to absorption from the stomach and subcutaneous connective tissue. It further avoids also the disturb-ing symptoms of irritation that all preparations of digitalis hitherto known, and however they are employed, set up at the site of application. Finally, by proper selection of the preparation to be employed, it permits us to avoid the toxic cumulative effect, and with it the last rock of digitalis treatment, as the intravenous treatment works with separate strokes, the effect of which we can observe and follow before sending a second dose after it. As digalen, that was first introduced into therapeutics by Naunyn, proved to be unsuitable for subcutaneous injection, on account of the irritation it caused, and as it also acted no more speedily than when introduced by the mouth, Kottmann, in order to get a quicker effect, ventured to inject it direct into the blood current, although pharmacologists up to the present are not agreed as to its chemical composition. Kottmann at first was not afraid to give doses even from the first of 5 to 10, and even 15 ccm.; but, bearing in mind an experience gained in the klinik at Berne, in which foudroyant cardiac death took place immediately after an intra-venous injection of o.6 strophanthin, he was more cautious in regard to dosage, and particularly in regard to digalen, and in a work published by him on the subject he recommends 1 ccm. as the initial dose, and only to proceed to larger doses when this fails to produce the desired effect, which, however, may be suitably replaced by small doses more frequently repeated.

It must appear striking that such large doses can be borne at all without doing any mischief when injected into the veins, especially when we assume, with Cloetta, that digalen is really pure, soluble digitoxin. Neither Kottmann nor Cloetta have been able to explain the non-poisonous nature of a substance otherwise so poisonous as digitoxin, and when employed in such

an energetic manner.

Digitalone, recommended by me for intravenous medication, is a preparation made from fresh digitalis leaves of a concentration of 1 in 10, and contains the most active principles of the drug digitoxin in a condition analogous to that of digalen, in which, according to the investigations of Cloetta only, it exercises a cumulative action when used in very large doses. For therapeutical purposes such doses, however, are not required in the case of digitalone, as it is not a single substance, but comprises all the active glycosides of the digitalis leaves, the combined action of which is necessary for an effect to be produced. As, how-ever, according to known pharmacological laws, the collective action of these substances is greater than the sum of their individual actions, in order to produce a sufficient effect digitalone requires such small doses that the unexpected conversion of increased cardiac activity into a toxic one, with diminished action of the heart, is excluded.

The intravenous infusion of this preparation of digitalis showed itself to be perfectly harmless. It neither causes irritation at the point of injection, nor any general or local disturbances whatever. On the other hand, signs of pronounced digitalis action appear within a short time of the injection, marked by more powerful systole, lengthened diastole, and increased

blood pressure.

This therapeutical effect of the single dose, which naturally can only lead to a permanent effect by a number of doses, sometimes comes on within a few minutes, sometimes later, and is more or less marked, according to the nature of the illness. But it is well to bear in mind that it reaches the height of its action generally after a few minutes, and its action ceases very gradually in from 24 to 30 hours. This affords sufficient indication of the time for repeating the dose, which for the adult is 2 ccm., but, with delicate individuals, the dose must be correspondingly less. If a therapeutical accumulative action is required, the injections must be repeated every 12 or 24 hours, and before the effects of the previous dose have passed off, whilst with relative insufficiency and so-called chronic digitalis treatment longer intervals are allowed (two to three days). In threatening conditions, where any effect at all could be expected, a single dose has proved sufficient to obviate the danger to life and relieve the distressing symptoms in a very short time. The almost absolute absence of danger of accumulation also allows us to send in whatever further injections are

required without anxiety

It must be conceded that in quickness and power these two cardiac remedies are exceeded by strophanthin-Boehringer, first recommended by Fraenkel. The action of strophanthin, which is injected in doses of mg., but which should not be given in frequent doses on account of the great danger of accumulation, acts, according to Fraenkel, like a charm, and commences within the first three or four minutes, the change of the pathological condition to the normal takes place before our eyes. The patient's pulse becomes fuller, his respirations are less frequent, and a flood of urine sets in such as we have never seen by any other means in such a short time. One patient who before the commencement of the treatment lav in a condition of apathy, with all the symptoms of over-loading with CO<sub>2</sub>, revived rapidly; another, who showed the appearances of excessive cardiac dyspnœa, and the restlessness and anxiety caused by it, became calm, and many, even after the first injection, regained the sleep that they had been deprived of for weeks.

In this remarkable action of a single dose of strophanthin, however, there lies a danger that must not be under-estimated. The diseased heart is called upon suddenly and immediately to do extra work; if the reserve power of the heart is equal to the requirements, the therapeutical effect is brilliant. But in other cases, in which the condition of the cardiac musculature is not one in which a response is possible, it will answer to the stimulation with diminished efficiency, and still greater disturbance of function, and in the worst cases even with sudden death.

A number of cases are recorded in which sudden death has taken place after injection of strophanthin. In making use of this remedy by way of intravenous injection, therefore, special care and caution must be used both as regards the indications and the dosage.

As regards the dangers of strophanthin, the

fact is important that the therapeutical dose and the toxic dose are very near each other, to which Liebermeister has lately drawn attention. Further, that it is extraordinarily cumulative, and may cause sudden

cardiac death without warning.

We know from experience that the cardiac remedies now discussed, even when given in the most efficient manner by intravenous injection, often fail like all other stimulants, or have only a transient effect, when the blood pressure sinks as from the absorption of septic material in peritonitis; the heart loses its power, and, with increasing weakness, the gravest circulatory disturbances threaten life. In such cases Heidenhain, after von Romberg and Passler, had determined the powerful action of adrenalin in raising the blood pressure, recommended the intravenous infusion of adrenalin-saline solutions, and in this way obtained an absolutely life-saving effect.

The method consists in the infusion of a litre of physiological saline solution, to which has been added 8 drops of solution of adrenalin. Rothschild, who made use of Heidenhain's treatment in an unusually bad case of peritonitis, describes its action as follows Even within a few minutes of the commencement of the infusion, the pulse improved, and quickly became strong and tense, and showed these qualities for halfan-hour after the completion of the infusion. In like manner the subjective condition improved with surprising quickness, and the ominous feeling of passing away gave place to one of well-being. Naturally, there is nothing to prevent a repetition of this, if necessary, and which may be required on further sinking of the blood pressure.

From this short statement we see the great importance of intravenous therapeutics in the treatment of disturbances of the circulation. The intravenous use of active remedies, when all other methods fail, enables us to give a powerful impulse to the flagging heart, and thereby turn aside the danger that threatens

(6) Various further Remedies for Intravenous Injection.

It was to be expected that, with the gradual further spread of intravenous injection, fresh proposals for the treatment of general infective diseases by that

method would soon be made.

The excellent effect produced by quinine when introduced into the veins in malaria, induced Lenzmann to try it in the second protozoa disease—syphilis, and he felt himself the more justified in this as other medicinal substances, atoxyl, had proved useful in both affections.

From a private communication of Lenzmann's, he now employs the following method in the treatment of syphilis :-

Quinin. lact., 10. Sod. chlorat., o.8. Aq. destill., ad. 100.

He first injects 2 gm. of this solution, and increases the daily dose to 0.5 in women and 0.7 in men. Slight giddiness and rush of blood to the head, as well as noises in the ears, come on with these large doses, but pass away quickly, and particularly as the patient gets accustomed to them. Lenzmann considers quinine to be an excellent remedy in syphilis, not equal to mercury in its action, but in cases in which only small doses of the latter are borne, or when there is any idiosyncrasy as regards the drug capable of doing excellent service.

If the statement of Lenzmann should be confirmed after extensive trial, the quinine treatment of syphilis

would be recognised as of great value.

Doevenspeck has tried 2 ccm. of a 5 per cent. solution of potassic iodide—o.1 gm. of the drug in syphilis, that required a rapid effect, and even from the first doses obtained a wonderful effect in the various stages of the disease, from the primary sore to syphilitic cerebro-spinal disease.

Unfortunately, I was not able to confirm these statements from my own observations. I have tried the treatment in a number of cases similar to those mentioned by Doevenspeck without the slightest trace of success. The nocturnal headaches did not disappear; ulcerations made their appearance, which, Doevenspeck said, were scarcely visible after the second injection, even when of great extent and threatening perforation, even after doses given repeatedly with only a tendency

to healing.

As, moreover, the injection of potassic iodide proved to be almost always painful, I have given up its further use by way of intravenous injection, as has been shown by carefully conducted experiments on animals, that the potassium salts, when introduced into the blood even in small quantities, cause a rapid diminution and final cessation of muscular movement, as well as a rapid cessation of the action of the heart in the animals experimented on, whilst, when given by the mouth or subcutaneous connective tissue, only much larger doses produce a fatal effect. The fatal dose corresponds exactly to the potassium constituent, and is not influenced to any degree by the metal constituent.

We see from these interesting animal experiments how necessary a full knowledge of the pharmacological properties of a medicinal substance is, as regards intravenous injection before it is applied in the way of

Now, according to the same experiments, the sodium salts, when injected into the blood in even many times larger quantities, have no influence on the heart nor any appreciable effect on the central nervous organs, or the muscles or nerves. In place of potassic iodide, therefore, I have used sodium iodide in 20 per cent. solution for injecting into the veins, and have injected 2 ccm. of this mixture, which was borne without either local or general injury.

But in syphilis, which appears to require large doses of iodine, I have never seen any improvement from this treatment; but, on the other hand, I have used intravenous injections of sodium iodide with remarkable success in parenchymatous struma, especially forms of Basedow's disease and arterio-sclerosis, concerning which I shall give a detailed account in another

As the duration of the excretion of sodium iodide depends on the kidneys-although this does not belong to treatment by intravenous injection—the intravenous injection of small doses of the drug, and the accurate control of its excretion, forms the most reliable indica-tion of the integrity of the renal functions when poured directly into the blood channels, the time of its in-corporation and the exact dose can be determined, whilst in the case of administration by the mouth the passage of the dose into the mass of juices, and the point of time of its entrance, depend on the condition of the intestinal tract at the time.

The proof that iodine is being excreted, and the length of time during which the excretion takes place, as shown by Bourget's reaction papers, give us a simple means of testing the function of the kidney, and also that of its eliminating power, one that is, at least, as reliable as testing with methylene blue, phloridzin and other things. In the case of harmless albuminurias, the duration of the excretion is always normal, whilst a considerably lengthened power in that direction, and is a significant with the direction and is a significant with the direction. that direction, and is a signum mali ominis for all cases of renal disease.

The period until complete elimination has taken place varies in healthy individuals, and the individual dose of 0.4 gm. takes between 20 and 30 hours, whilst in cardiac and renal cases a similar dose can often be traced in the urine and saliva for more than 50

or 60 hours.

As two further therapeutic attempts to treat acute infective diseases by way of intravenous injection, I would first mention that of Charles Barrow, who used would first mention that of Charles Barrow, who used a solution of formaline (1 in 5,000) in a case of puerperal septicæmia with a remarkably good result, and, further, the injection of a solution of nitrate of silver (500 ccm. of a 1—10,000), first recommended by Hume and tried by Schatski and Grjasnow. According to these authors, the injection, after a short general restion (favor rigors etc.) has a favourable effect not action (fever, rigors, etc.) has a favourable effect, not only in genaral infections, but also in local ones having marked toxic symptoms.

The most recent of the attempts to treat cases by means of intravenous injection is that of Van der Velden, who injected 3 to 5 ccm. of a 10 per cent. solution of chloride of sodium in a case of hæmoptysis, and obtained a measurable increase of coagulability of the blood in the course of 2 to 4 minutes. By this simple treatment, which probably depends on mobilisation of the thrombokinasis from the tissues, Van der Velden has obtained good results. From this basis it may well be expected that this treatment will prove successful in hæmorrhages from other causes that are difficult to arrest (ulcer of the stomach, intestinal hæmorrhages, etc.)

Finally, I would like to mention a thiosinamine combination (fibrolysine) that has been injected both into the muscles and into the veins in doses of 2 to 3 g. of a 10 per cent solution, when the softening action on cicatricial tissues takes place very quickly, both in my own experience and in that of other authors.

With the above I believe I have given a fairly com-

plete account of the present position of intravenous therapeutics, and have at the same time shown the great practical importance of our method of treatment, which in the most varied forms of disease has shown itself effective when every other method of administering medicines has failed.

We must confess that intravenous therapeutics makes we must comess that intravenous therapeutics makes special demands on the caution, care, and dexterity of the physician, and that a number of difficulties that are not to be under-valued are associated with it; but, in the interest of our patients, we must take them as they come, willingly, when in exchange for them we acquire certainty of dosage, increased efficiency, as well as painlessness in the administration of our remedies. of our remedies.

NOTE .- A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by G. Milian, M.D., Physician to the Peris Hospitals. Subject: "Hemiplegia due to Syphilitic Artoritie.

#### ORIGINAL PAPERS.

#### SURGICAL AID IN CHRONIC ULCER OF THE STOMACH. (a)

By J. A. NIXON, M.B.CANTAB., M.R.C.P.LOND., Physician to the Bristol Royal Infirmary.

A constant succession of dyspeptics, some alcoholic, some phthisical, all full of strange complanings in terms borrowed, for the most part, from soul-stirring newspaper advertisements, passing rapidly through an out-patient clinic, is calculated to blunt one's interest, and to lull one into the passive belief that none are ever cured, and that the majority of them may be relieved by copious irrigation of the stomach with concoctions of rhubarb and gentian. Invaluable as this remedy proves in a great number of cases, it cannot be regarded as a panacea for every variety of digestive disturbance, and of late years its pre-eminence has been challenged by the surgeon. The operative treatment of chronic gastric ulcer has been attended by such noteworthy results that the physician is tempted sometimes not to discriminate too closely, but to submit any and every case of indigestion to operation, with the inevitable penalty of disappointment.

Whether gastro-enterostomy in one of its forms is the best operation that can be devised, or whether some better procedure will presently be introduced, is not the object of discussion in this paper. So far as it goes it is a good operation; it relieves the patient under certain conditions; and the duty of the physician (in the intervals of suggesting fresh plans for operation to the surgeon) is to endeavour by every means in his power to select those cases that are likely to benefit from surgical interference, and learn to know those in which no good results are likely to follow.

The cases under my care which have been operated upon, in the belief that a chronic ulcer of the stomach or duodenum was present, are shown in the following

Ten cases suspected of chronic ulcer do not form a large series from which to arrive at general conclusions, but they provide illustrations of the difficulties en-

ditions which surgery will relieve.

Case 1.—T. C. G., a man, æt. 53. Eleven years previously suffered from vomiting (daily for three weeks), with a single large hamatemesis. Six years ago treated for gastric ulcer, and again one year ago when he vomited frequently, sometimes "coffee grounds." No pain or tenderness, no gastrectasis, some indefinite resistance in epigastrium. Argyll-Robertson pupils, knee-jerks present, no inco-ordination, analgesia in arms and legs. Free HCl absent, and lactic acid (0.129 per cent.) present in gastric juice.

Here there seemed so much room for doubt that, in spite of recognising the fact that the man was probably suffering from spinal sclerosis, operation was advised. It was possible that there was some old ulcer or carcinoma of the stomach, and the general condition of the patient was fair. An exploration was made, no ulcer or growth was found, gastro-enterostomy was performed. Three months later he was well except for slight fulness after meals. Subsequently the vomiting recurred temporarily. The conclusion is that these attacks are gastric crises, yet there was good reason for believing it might be otherwise, and the patient suffered no ill-effects from his operation.

CASE 2.-A. H., a man, æt. 32. Four years ago was warded for a month on account of vomiting blood and diarrhœa, one year ago a similar attack lasting six weeks. A fortnight before admission he had vomiting with blood. Vomiting always occurred soon after food. Painful spot in the nipple line just below left hypochondrium. Extreme emaciation. No signs of other

At the operation no ulcer, growth, or adhesions were found, but gastro-enterostomy was performed. Immediately the man improved and put on flesh (this had not been the case under medical treatment), but he has relapsed several times. Once he developed an ulcer of the larynx, and several times since he has had numerous

(a) "Bristol Medico-Chirurgical Journal," September, 1908.

small superficial ulcers in the mouth, suspected variously of being syphilitic or tuberculous. On the last occasion he came under observation it was evident that these ulcers started as blebs. Perhaps pemphigus is their true origin. Still, the improvement after operation was remarkable, and the patient has never seen reason to regret its performance.

CASE 3.—M. C., a girl, æt. 14, who had persistent vomiting of food with so much epigastric tenderness and pain of paroxysmal character that, although she had a few pleural crepitations at the right base, it was decided to perform an exploratory laparotomy. She urged us to operate, the pain was so severe, and she was so sure of its localisation.

Mr. Carwardine explored, and found an abnormal attachment (? congenital) of the omentum to the anterior abdominal wall; this he divided, but did not open the stomach. There was no external sign of ulcer. Eventually she developed extensive diffuse phthisis, and her pain was in no way relieved Doubtless this pain was connected with a diaphragmatic pleurisy.

CASE 4.-F. C., a girl, æt. 19, with a history of six years' indigestion, constant pain relieved by lying down; vomiting at no definite time after meals; three years ago a single hæmatemesis; slight epigastric tenderness, no gastrectasis. She described her pain as so severe, so localised, and as making her life such a burden, that she begged for an operation "to see if there was not something there." Medical treatment had always failed to do any good.

Mr. Munro Smith operated, and found a stomach firmly adherent on its posterior aspect to a mass feeling the size of a cricket ball, which presented no prospect of safe removal. Gastro-enterostomy was performed. There was complete relief from pain; no recurrence; the girl put on flesh; two and a-half years afterwards could eat "just anything," and was happily married.

CASE 5.—L. D., a girl, æt. 18, with the appearance of a fairly healthy child of 12 (Lorain's infantilism). Epigastric pain, worse after food, for two years. Hæmatemesis (Oj) nine months ago, and one month later. Great cutaneous hyperæsthesia in epigastrium. Enormous gastrectasis, greater curvature just over pubes. Had menstruated once at 13, absent since.

Gastro-enterostomy performed by Mr. Carwardine. Inflammatory tumour found, completely obstructing

pylorus. The relief was immediate, the child grew into a woman in a few weeks. The stomach remained distensible for many months, and at rare intervals there was vomiting. The weight increased in eight months from 6 st. to 10 st. 3 lb. After six months the stomach could no longer be abnormally distended with seidlitz powder. Eighteen months after operation was in excellent health and appeared a healthy young woman of 20; catamenia regular.

CASE 6.—A. H., single woman, æt. 34. Indigestion on and off since childhood. Hæmatemesis three years ago. Pain directly after food, temporarily relieved by medical treatment. No vomiting, no tenderness, no

gastrectasis.

Laparotomy by Mr. Carwardine. Hour-glass stomach, also scarred duodenal ulcer obstructing pylorus. Gastro-jejunostomy and gastro-gastrostomy performed. The relief from operation was considerable, but at times indigestion returns (eighteen months after operation). The patient is very glad she was operated on.
CASE 7.—M. V., matried woman, æt. 37. Fourteen

years ago vomiting after food with streaks of blood; irdigestion on and off ever since. Pain directly after food in epigastrium and back. Water-brash, gastrectasis, lump felt in epigastrium. Gastric juice, free HCl, no lactic or butyric acid.

Gastro-enterostomy by Mr. Carwardine. Duodenal adhesions and considerable dilatation of stomach found (? duodenal ulcer). Marked relief of indigestion

and water-brash, continuing for two years.

Case 8.—C. G., single woman, at. 37. Frequently under treatment for dyspepsia during past sixteen years. Pain about one hour after meals, relieved by vomiting. Hæmatemesis eight years and six years ago. In latter years vomiting less frequent, but the desire to vomit has increased. Superficial cutaneous hyperæsthesia and some deep tenderness in epigastrium. No gastrectasis.

Gastro-enterostomy performed by Dr. J. Swain. Pylorus not apparently thickened, no ulcer found, but very great relief from the operation. The patient is a maid at the Bristol Royal Infirmary, and is under constant observation. Her satisfaction ten months after operation is undiminished. operation is undiminished.

CASE 9.-K. S., married woman, æt. 46. For twelve months had complained of pain just below left hypo-

ANALYSIS OF CASES.	Result.	Temporary Relief.	Partial releif.	Relief.	Relicf.	Relief.	Relief.	Great relicf.	Relief.	Relief.
	Condition found.	No ulcer found	No ulcer found	Old gastric ulcer with Relief.	adhesions Old pyloric ulcer with	complete stenosis  Two ulcers. Gastric	and duodenal Old duodenal ulcer	No ulcer or adhesions	Old ulcer on lesser curvature with much	puckering Old pyloric ulcer ? carcinoma
	Dilata- tion.	oN	:		Yes	. oN				Yes
	-	- ا ا	<del></del>	: :	Yes	No.	Yes	No	; °	Yes
	Hæmatemesis.	5	:	: :	:	:	:	:	:	:
		Twice	Twice	Once:	Twice	Once		Twice	:	:
		Yes. Twice	Yes.	No. Yes.	Yes.	Yes.	oN	Yes.	No.	No O
	Vomiting.	IT.C.G. II years No Yes. Frequent Yes. Twice	Yes. After food Yes. Twice No	3.—M.C 6 months Paroxysms   Yes   No   No. 4.—F.C 6 years Constant Yes. Without rela-   Yes. Once   No	tion to food to Twice Twice Twice Twice	No Yes. Once		Yes Yes. Twice	Yes. After food No.	10J.M 5 years After food . Yes. A pailful at a time
	Pain.	No	Constant	Paroxysms Constant	After food .	6.—Annie H From child- After food . No	7.—M.V 14 years After food . Yes	One hour	after food One hour after food	After food .
	History.	11 years	4 years	6 months	2 years	From child-	hood 14 years	8.—C.G 16 years One hour	9K.S I to 2 years	5 years
	case.	1.—T.C.G.	2.—A.H	3.—M.C.	L.D.	6.—Annie H	7.—M.V	8.—C.G	9.—K.S	10.—J.M

chondrium one hour after food. Sickness after every meal, which used to relieve the pain, but later ceased to do so. Always free from pain when constipated or when lying down. Never hæmatemesis. Slight tenders in epigastrium, no gastrectasis.

Operation by Mr. Bush. Marked puckering along lesser curvature of stomach, an indurated mass involving equally anterior and posterior surfaces, and reducing the length of lesser curvature to one-half of Gastro-enterostomy performed with complete normal. and lasting relief (one year later).

and lasting relief (one year later).

CASE 10.—J. M., man, æt. 55. For five years pain after food, vomiting (a pailful at a time) for twelve months. Progressive wasting, lemon tint of skin noticed by friends. Gastrectasis, visible peristalsis, lesser curvature just below umbilicus. A firm "knob" felt at right edge of right rectus when peristalsis reached this point. Liver dulness displaced downwards but not enlarged. Gastric juice: free HCl absent.

absent.

Operation by Mr. Hey Groves. Pylorus thick and nodular, anterior surface marked by scar to which omentum adhered; complete pyloric stenosis. Gastroenterostomy performed and piece of tumour removed for examination. Pathological report: At first only inflammatory tissue found, but later in posterior pyloric wall undoubted area of columnar-celled car-cinoma. Twelve days after first operation Mr. Groves performed pylorectomy. The patient made a good recovery and experienced great relief from the operation (after six months).

Analysis of seven cases improved by operation:-

... 7 cases. Pain present in Vomiting present in... Hæmatemesis present in ... 4 cases. ... 3 cases.

Stenosis present in ... ... 3 cases.

In discussing these cases one is tempted to look for some leading symptom or combination of symptoms, or to hope for some mechanical (chemical or otherwise) method of arriving at a diagnosis of chronic ulcer of the stomach. But excepting pain and vomiting, there seems no other reliable sign, and these two are shared

by many other diseases.

Gastric contents.—Little or no help is derived from the test-meal, and the presence or absence of this or that constituent. A considerable experience of "test-meals," carried out in various hospitals upon the subjects of many diseases, carries with it the conviction that "test-meals" offer absolutely no reliable division of gastric means oner absolutely no reliable division or gastric cases into those which will and those which will not benefit by operation. Hyperchlorhydria, hypochlorhydria, achylia gastrica, deficient or increased motility, will none of them give the unfailing indication.

Gastrectasis is by no means necessarily present in the cases which profit most by gastro-enterostomy.

Tumour.—The presence of a palpable tumour means very little in the diagnosis between inflammatory tissue and neoplasm; its absence has no bearing on the question of a profitable or unprofitable operation.

Hamatemesis or Melana.—Both these signs are most

misleading. Hæmatemesis in small quantities as described by the patient is most difficult to distinguish from hæmoptysis. Malignant disease, especially in the early stage, occasionally causes a single large hæma-temesis. Duodenal ulcer is not uncommonly associated with hæmatemesis and melæna from regurgitation of blood through the pylorus. The erosion of the liver by an adherent simple ulcer will give rise to constant "coffee-ground" vomiting.

Hæmatemesis from a general oozing of the gastric mucosa (gastrostaxis) is not unknown, may be very

cutaneous hyperasthesia, especially galvano-hyperasthesia, may be of great help in diagnosis. The absence of this sign need deter no one from operation

if other indications are present.

The chief guide to operation is the patient as a whole. A long history of indigestion, with vomiting and occasional attacks of hæmatemesis dating from early adult life (I begin to think that gastric ulcer is not so very rare in children of 12 or 14) will form the foundation of most accounts of chronic ulcer. While to these may be added epigastric pain—pain before food, directly after food, an hour or two after food, and pain all the time; the sufferers from ulcer of the stomach or duodenum know all these variations. A resistance, thickening, or definite lump in the epi-gastrium only forms an additional reason for operating; and gastrectasis with visible peristalsis as ascertained by inflation with CO<sub>2</sub> clinches the matter.

Operation is indicated in:—

(a) Painful ulcer.

(b) Recurrent hæmorrhage.

(c) Pyloric stenosis.

In these three conditions there will probably be no difference of opinion as to their suitability; but there is one more class, consisting of chronic dyspeptics, who, having honestly tried medical treatment, find themselves unrelieved. With the proviso that operation is not undertaken for the following conditions, they should be operated on:—

(1) Chronic alcoholism or drug-taking.

(2) Gastric crises.

(3) Phthisis.

(a) Dyspepsia. (b) Hæmoptysis.

(c) Diaphragmatic pleurisy.

(4) Mitral stenosis.

(a) Pain.

(b) Hæmoptysis.

(5) Cirrhosis of liver.

(6) Chronic Bright's disease (dyspepsia).

(7) Renal colic.

(8) Addison's disease (nausea, vomiting and faintness).

(9) Overloaded or distended colon.

(10) Arsenic poisoning.

Atonic dilatation.—Clifford Allbutt says that "the frequency of dilatation of the stomach as a complication or sequel of acute disease is not sufficiently appreciated" in the estimate of the causes of dilatation of the stomach not depending on pyloric stenosis, and he quotes (not in agreement) "a London physician of almost singular eminence" who said to him "that of dilatation of the stomach apart from pyloric obstruction he knew nothing." Yet, except during convalescence from an acute disease, I believe the diagnosis of "atonic dilatation" should be received with the utmost scepticism. It has been quite astonishing to find how frequently the post-mortem or (in modern times) the operating table has shown an obstructive cause for the so-called atony. Unless such a case yields very quickly to diet and treatment, it should be explored.

For general neurotic symptoms co-existing with a dilated stomach no great respect is demanded. Constant dyspepsia is as liable to cause as to be caused

by "a general neurotic disposition."

Our army of neurasthenics is an ever-diminishing one, and as a disinterested observer of a very large number of surgical operations, I shall never make the diagnosis of "gastric neurosis" with complete assurance, nor hear it made without a lurking suspicion that some day surgery will "inconveniently confront us" with something more tangible than our own maxims, and a very solid basis for the hypochondriacal disorder.

In a very great measure the patient is his or her own, and our best guide, if, being of sound mind and appreciating fully the risks, such an one comes deliberately to the conclusion that the pain, vomiting, discomfort and emaciation make life no longer worth living. Then, in the absence of other contraindications, we are amply justified in advising, if not gastro-enterostomy, at least an exploratory laparotomy.

One last word on the after-treatment. After a gastro-enterostomy has been performed by any of the present methods, there are constantly being reported disappointments of one sort or another, and various mechanical explanations have been given, vicious circles talked of, and numerous twists and kinks given to the gut in order to circumvent the difficulties. In point of fact, is the after-treatment always sufficiently cautiously proceeded with? My experience with the operation may be exceptional, but I have not encountered as yet one of these results, perhaps because the patients have usually continued for about two months after operation a course of dieting and treatment precisely as though they were recovering from acute ulcer with harmatemesis.

## ON THE FEEDING OF INFANTS WITH UNDILUTED CITRATED MILK. (a)

By FREDERICK LANGMEAD, M.D., M.R.C.P.,

Physician to Out-Patients at the Paddington Green Children's Hospital, and the Seamen's Hospital, Greenwich; Casualty Physician to St. Mary's Hospital.

It is generally agreed that few infants in the earlier months of life can digest unmodified cow's milk. The reason is not far to seek. If we take unchanged cow's milk, acidifying it with hydro-chloric acid, and then digest it with rennet, in other words, if we imitate in vitro the process of digestion in the infant's stomach, we find that the milk forms a dense tough curd. The clot of human milk, on the other hand, is soft and flocculent. The difference in the two clots is an obvious explanation of the greater indigestibility of cow's milk. This inference is confirmed by clinical experience, for with digestive disturbances tough curds are vomited and evacuated. The infant's stomach is not like the calf's, for it is unsuited to this large firm curd. Dr. Eric Pritchard (1) has pointed out, that the volume of the cow's stomach represents about 60 per cent. of the alimentary canal, whilst the volume of the human stomach is only 20 per cent. of that of the digestive tract. If we are to utilise cow's milk for infant feeding it is plain that we must discover the cause of the greater density of the curd, and prevent it. Until recently all our attention has been fixed on the chief chemical difference in the food constituents of cow's and human milk-viz., the excess of proteid in the former and the relatively greater proportion of casein. We argued in this way: "The curd is due to casein: casein is in excess in cow's milk; clearly the procedure to follow is to dilute cow's milk and so decrease the proportion of that proteid." By dilution the fat and sugar are reduced to inadequate amounts, and more has to be added artificially to correct this fault. A complicated method of feeding has thus arisen by which a different dilution is used for each month, and consequently varying additions of sugar and fat are required.

The other important factor in the phenomenon of coagulation was almost lost sight of—viz., the calcium salts. These are in considerable excess in cow's milk. Bunge gives the proportion of lime salts in human milk at .03 per cent., and in cow's Pages showed that clotting could be entirely prevented if the calcium salts were precipitated by the addition of oxalates or fluorides. No practical value was attached to this experiment until Sir Almroth Wright published a short paper in the Lancet in 1893, in which he showed that a similar result could be obtained if sodium citrate were added to the milk instead of the poisonous salts used by the two physiologists. As the outcome of a series of experiments, he found that a soft flocculent curd like that of human milk could be obtained by the addition of 2 grains of citrate of soda to an ounce of milk. He therefore suggested that infants might be fed on cow's milk, to each ounce of which 2 grains of this salt had been added. After a latent period of about eleven years Dr. Poynton was the first to partially test this method on a sufficiently large scale. In 1904, in a paper in the Lancet, he recorded the success which he had obtained with citrated milk, but he had deviated from the original suggestion of Sir Almroth Wright in that he had combined citration with dilution and had used only I grain of the citrate

to the ounce of milk.

About two years ago, at a meeting of the St. Mary's Hospital Medical Society, Sir Almroth Wright again advocated citrated undiluted milk. It was my privilege to be present at that meeting, which determined me to try this method of feeding for my out-patients at the Paddington Green Children's Hospital.

There is much to be gained by using undiluted milk. First, the food is given in a more concentrated form, and thus the liability to distension of the stomach is lessened; there is little doubt that much of the vomiting of infancy is due to physical rather than to physiological over-burdening of the stomach. Secondly, there is no need to add cream or sugar. This is of great moment to the poorclass mother who cannot afford to buy cream; which, moreover, in London, is difficult to procure free from preservative. We all know the importance of adding cream to diluted milk, yet how soon we learn also that to order it is mere waste of words! Thirdly, we avoid the calculations necessary when using diluted milk. The different dilutions at different ages, and the consequent varying amount of cream to be added, is too great a task for most mothers. Fourthly, less manipulation is required. This is always an advantage, and when dealing with slum children is one which can scarcely be overestimated.

But even remembering these great advantages, I do not think I should have ventured to depart so widely from the orthodox method, in which difficulties are met by ever-increasing dilutions, did I not know that others had successfully employed whole milk. Professor Budin, of Paris (2), has for many years fed infants on undiluted milk; sterilised by heating at 100° C. for 45 minutes, thus rendering the curd much softer, and his results have been remarkably favourable. Many other Continental physicians have followed his example. I knew also of some few pioneers in London who had fed their own babies on undiluted citrated milk, and whose temerity had been rewarded by seeing them grow strong and well.

For more than two years I have employed citration without dilution, and am more than gratified by the results. The exact method of procedure I employ is as follows:-When the baby is first brought to the hospital, supposing it is not thriving on artificial feeding, it is weighed and its weight is recorded on a chart which has been devised for the purpose; the number of feeds per diem and the amount of each feed are then determined upon. No hard-and-fast line can be drawn either with regard to the frequency or size of each meal, since so much depends upon the size and vigour of each particular child and on its previous feeding; but the following rule affords a useful standard:-For the first five weeks of life, as far as possible, meals are prescribed every 2 hours, for the second five weeks every 21 hours, and afterwards until the sixth month every 3 hours. This, of course, applies to day feeding only. By nighti.e, from 10 p.m. to 7 a.m., 2 meals are given during the first 3 weeks, one during the second three weeks, and afterwards the meals are slightly re-arranged so that the baby goes without the bottle from 11 p.m. to 5 a.m.

By Day.—1 to 5 weeks, 2 hourly feeds; 5 to 10 weeks,  $2\frac{1}{2}$  hourly feeds; 10 weeks to 6 months, 3 hourly meals,

By Night (10 p.m. to 7 a.m.).—1 to 3 weeks, 2 meals; 3 to 6 weeks, 1 meal.

For quantities I use the following table, recommended by Holt (3), slightly modified:—

FEEDI	APPROXIMATELY.			
	ozs.		ozs.	
1st week	i — iss	===	i	
2nd-3rd week	iss — iii	=	ii	
4th 5th ,,	iiss — iiiss	==	iii	
6,, 12,, ,,	iii — ivss	==	iv	
3rd 5, month	iv — vss	==	v	
5,, 9,, ,,	vss — vii	=	vi	
9,, 12,, ,,	viiss — ix	=	viii	

This table errs somewhat on the side of liberality when dealing with undiluted milk, and so I always start somewhat below the figure here given, for gastro-intestinal disturbances are the result, not of too little, but of too much food. Of necessity, there are many cases of infants far below the normal weight, and with powers of digestion, for whom a meal far smaller than the average is essential.

I then prescribe for each ounce of milk ordered 2 grains of sodium citrate, and this is given in the form of a watery solution, 1 drachm of which has to be put into each feed. For example, if 4 ounces of milk are given every 3 hours, the prescription is thus:—

Sodii citratis, oz. viii. Aquam ad., dr. i.

3 bis in die.

The mother is instructed to bring the milk to the boil, and then to add one teaspoonful to each feed. Sodium citrate is very soluble in water, so that it is possible, no matter how many ounces of milk are being given at a feed, to dissolve the citrate in I drachm of water.

By raising the milk to the boiling-point we destroy the living pathogenic micro-organisms, The report of the Medical Officer of Health for the City of London shows that this is not an unnecessary refinement. Between July and September, 1908, 23 per cent. of the samples of milk examined proved to be tuberculous, and even now, after the active pure-milk crusade, 7.7 per cent. contain living tubercle bacilli out of 285 samples. By this means, too, we render the clot still more flocculent.

At subsequent attendances the child is weighed again, at first weekly, afterwards fortnightly or every three weeks, and its weight is duly recorded. The amount of milk given is adjusted to the progress of the child, which is estimated by its general condition and the evidence of the scales. At about five months of age citration is gradually diminished, until the advent of teeth permits of unaltered milk and a more extensive dietary. If weak citrate solution is kept in a warm place a fungus is apt to grow on the surface, but this is avoided by adding a few drops of chloroform water. Equally good results are obtained if the citrate of soda is added to the milk in bulk instead of in each feed.

This method is so simple that the mother cannot easily make a mistake in preparing the milk, which is a great advantage. It requires little manipulation. It produces in the stomach a fine flocculent curd which infants can deal with, who have been screaming frequently, drawing their legs up and showing other evidences of indigestion after diluted milk. There is no danger of rickets, for it is only the excess of calcium salts, which is thrown down, which even then is still given in the milk. Moreover, Dingwall Fordyce (4) has fed rats on citrated milk, and no rickets has resulted. There is no danger of scurvy.

RESULTS.

I have now watched several of these patients from early infancy until dentition, some of whom weighed far below the average when they were first seen, and am able to say that they became strong, well-developed infants, and that rickets does not

Constipation is said to be the most troublesome effect, but I have been unable to satisfy myself that it is more in evidence in babies fed on citrated than on other forms of modified milk. The stools are more bulky, but in those patients in whom constipation has been serious it was so before they came under treatment.

Some seventy cases have been treated in this way. They were all children who were wasting under other methods of feeding. In any case in which the mother's statement that the child was getting thinner seemed to want confirming, two weighings were first taken, the first on the child's first attendance, the second after a week's interval. Many were marasmic, two or three weighing about 5 lbs. at ten weeks to two months of age. The previous feeding had been by the breast, by diluted cow's milk, and by many kinds of artificial foods. One was fed entirely on albumen-water as a last resort; three, according to their mothers' statements, were brought because they had been given up by their doctors; and in one instance a medical certificate of death had already been promised. Some have been lost eight of, as always happens in hospital practice, but, with the exception of two or three who attended for about one week only, all have gained steadily in weight, many making up for lost time and reaching normal, and above, before citration was replaced by unaltered milk.

In a lecture which I gave before the Medical Graduates' College and Polyclinic, in March, 1908, I said that I regarded this method of infant feeding as the most satisfactory which we possessed, and now, after another year's experience of its use, I am of the same opinion. I have met with no cases in the last two years in which I have found it advantageous to replace it by other kinds. must, however, be clearly understood that it is a method of feeding simply, and not a therapeutic measure such as would be required in cases of epidemic or summer diarrhœa, in which, of course,

no milk of any sort should be given.

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CIRCULAR, February 17, 1909.

(2) Prof. Budin: "The Nursling," translated by W. P. Maloney. 1907.

(3) Prof. Holt: "Diseases of Childhood," New York, 1907.

(4) Dingwall Fordyce: Scottish Med. and Surg. Journal, October, 1907.

#### CHRONIC ŒDEMAS DUE TO LOCAL DEGENERATIVE CHANGES.

BY F. PARKES WEBER, M.D., F.R.C.P., Senior Physician to the German Hospital, London, and Physician to the Mount Vernon Hospital for Chest Diseases, Hampstead.

Every medical man has probably occasionally come across cases of acquired chronic cedema of the feet, ankles and legs (often more marked in one lower extremity than the other) which occur in elderly persons, sometimes suffering from chronic rheumatoid arthritis or chronic gout, and which do not seem to be caused by any disease of the circulatory, respiratory, or urinary organs, or to belong to the class of toxamic cedemas, or to be connected with abnormal chloride-retention in the tissues. In such cases the cedema remains stationary for a long while, causes very little inconvenience, and will not yield to cardio-vascular tonics, diuretics, or any kind of drugs, though it can be temporarily removed by rest in bed and massage. There is

generally some personal and familial "arthritic" history forthcoming, and cedema of this type has often been described as an arthritic, chronic gouty, or chronic rheumatic manifestation, probably due to some alteration in the minute blood-vessels and to the effects of gravity on the lower extremities. Obesity, weak cardiac action, and low bloodpressure doubtless sometimes play a part in its production, but the patients are not always corpulent, and the blood-pressure is, I think, by no means always low. In a man, aet. 75, now under my care there is a history of his having had an attack of chronic cedema of the legs (not due to nephritis) very many years ago, which disappeared after some time under treatment by limitation of diet and a saline alkaline laxative. He has always been an active man, inclined to "good living" and corpulence. The attack of "dropsy" of the legs many years ago, whatever its cause may have been, probably predisposed the legs to the present form of chronic odema. I do not think that chlorideretention plays any part in the present trouble; special attention paid to this point in the diet has made no difference in the cedema.

The fundamental cause of the cedema in some, at least, of these cases appears to me most likely to be some degenerative change in the corium and subcutaneous tissue, perhaps specially involving the yellow elastic fibres and unstriped muscle fibres, and resulting in a loss of tissue-elasticity, that is to say, in a diminution of what may be termed the "elastic tonus" of the affected tissues. I would compare this change to the loss of elasticity in the lungs, which, occurring in the same types of individuals, gives rise to ordinary pulmonary emphysema (and probably sometimes predisposes to chronic catarrhal or cedema-like conditions of the bases of the lungs).

Another chronic condition which I believe is due to a similar diminution of "elastic tonus," and which not rarely occurs in the same types of individuals is the peculiar bulging or "puffiness" of the skin (subcutaneous tissue), giving rise to the "cushions" below the eyes, which are fairly commonly met with in elderly and degenerative individuals with arthritic personal and family history. In some such cases it appears as if the degenerative loss of tissue-elasticity not only induces an œdemalike puffiness, but likewise favours the growth of subcutaneous fat, and in such cases the puffy "cushions" below the eyes may be compared to the condition in the upper eyelids known as "ptosis adiposa" or "blepharochalasis," which may occasionally occur as a congenital abnormality, though it is more often met with as an acquired senile or degenerative condition. It is probable that these "infra-orbital cushions" and "ptosis adiposa," when congenital or appearing in early life, bear the same relation to the similar acquired conditions that cases of congenital or early developmental "trophœdema" (a) of one or both lower extremities bear to the degenerative chronic ædemas of the legs now under consideration.

In regard to the treatment of these "degenera-tive" chronic cedemas of the lower extremities, it follows that both local and general methods may be The local treatment consists in outside useful. support (bandaging, etc.) and massage, whilst the general treatment should be directed to improving the general health and delaying degenerative pro-

<sup>(</sup>a) In regard to the role of tissue-elasticity in the causation of trophodems, see F. P. Weber, remarks on trophodems in the discussion at the Royal Society of Medicine, Clinical Section, December 11th, 1908 (Proceedings, vol. ii, pp. 52, 53, and 61 to 63). In regard to the occasional combination of fatty with chronic odematous swellings it is worthy of mention that chronic trophodems of the lower extremitles has in two or three instances been accompanied by a pendulous lipomatous-like swelling of the subcutaneous tissue at the lower posterior part of the thigh.

cesses as far as possible by appropriate dietetic and other means. Amongst such means, the careful employment of thyroid extract might prove of service in a few cases, in which partial degenerative changes in the thyroid gland play a part in the pathogeny of degenerative and trophic changes elsewhere in the body. I do not think that a trial of calcium treatment is indicated in most of these cases.

## IONISATION IN THE TREATMENT OF SKIN DISEASE. (a)

By E. GRAHAM LITTLE, M.D.Lond., F.R.C.P.

AFTER some preliminary remarks on the theoretical basis of therapeutics by ionisation, Dr. Graham Little said he had had most experience with the zinc ions, which he had used with considerable success in cases of lupus vulgaris, lupus erythematosus, rodent ulcer, epithelioma, pigmented flat senile warts. The method of administration in all the cases had been similar. A galvanic battery consisting of twenty cells had been used. The positive pole had been connected with an electrode made of chemically pure zinc, the size of the electrode being graduated to the size of the patch to be treated. Where the electrode did not fit the area requiring attention, a hole had been cut in oil silk sufficiently large to expose the diseased part while protecting the healthy skin from the current. The electrode was covered with four or five thicknesses of absorbent gauze, sterilised by boiling in distilled water, and soaked in a 2 per cent, solution of zinc sulphate in distilled water. The electrode should be pressed firmly upon the skin and the current gradually introduced, cell by cell, until about 6-10 ma. were obtained, if the patient could stand the larger limit. Most patients could tolerate about 7 ma, with comparative fortitude. For lesions in which the skin was much indurated, or in which the surface was uneven, a preliminary application for some days of Beiersdorf's salicylic plaster, 25 per cent., had been useful in macerating and settening the skin. The patch to be treated should be carefully cleansed with absolute alcohol or hydrogen peroxide, and then with boiled water. The duration of the current depended on the nature of the disease and the stoicism of the patient; from 10-25 minutes would be an average time. Probably the sittings had creed on the side of shortness. The chief means of mitigating the pain was to introduce and withdraw the current gradually; the pain was really not as severe as might be thought; quite young children had stood twenty minutes with 6 ma. without serious flinching. In a case of lupus vulgaris in a delicate woman, a preliminary subcutaneous injection of cocaine had been useful in checking pain. In rodent ulcer, especially of the ulcerative stage, the treatment had succeeded admirably in at least four cases in which X-rays had comparatively failed. In lupus vulgaris the results were also very promising, but a greater number of sittings had been necessary. The effect of the treatment, as shown in two cases exhibited to the meeting, was to thin the indurated lupus patch, and to produce finally a good scar. In lupus crythematosus the best results of all had been obtained; the sittings averaged about fifteen minutes, and the scar left by the disease was particularly good. An important point was that there was little danger of doing harm or of promoting the spread of the invasion, a risk which was not negligible in many forms of treatment for this affection. A case of extensive lupus erythematosus of the semi-acutevariety was shown, in which the disease had been checked and cured by this treatment. In a case of epithelioma, shown at the meeting, which had originated in a pigmented naevus, the hardening of the epitheliomatous infiltration had been distinctly lessened by three treatments of fifteen minutes with zinc ions, and this case had failed to react to X-rays—moreover its position near the eye made the use of X-rays undesirable.

#### OPERATING THEATRES.

GREAT NORTHERN HOSPITAL. AMPUTATION OF PENIS FOR CARCINOMA.—MR. ARTHUR EDMUNDS operated on a man, æt. 55, who was suffering from a small carcinoma on the under-surface of the glans penis involving the frænum and the prepuce. The growth was of the hard, ulcerating, and nonfungating type. Glands could be felt in both groins, especially on the left side. The question that first presented itself, Mr. Edmunds pointed out, was whether a complete or a partial removal should be undertaken. This was a point difficult to settle. In the first place, amputation of the penis at the level of the scrotum is a very unsatisfactory operation. As sexual organ it is obviously useless, and micturition is liable to be accompanied by exceriation of the surrounding tissues. If the growth is so limited that amputation can be performed just behind the corona glandis, the functional result may be good; but in the present case it was impossible to perform such an operation with any reasonable hope of permanent cure, and it was decided to perform a complete amputation of the organ, trans-planting the urethra into the perinæum. This opera-tion, Mr. Edmunds said, had the disadvantage that, although the corpora cavernosa are entirely removed, the corpus spongiosum must be left for a certain distance.

The patient was placed in the lithotomy position, and a sound passed into the bladder so as to identify the urethra. An incision was then made in the middle line of the perinæum, about 2 in. long, exposing the bulb, and, with a little dissection, the crura of the corpora cavernosa. The spongy urethra was then identified and isolated from the surrounding structures; the sound was then withdrawn, and the vrethra cut across, leaving a portion sufficiently long to reach the skin without tension. The corpora cavernosa were then detached from the sides of the pubic arch, and in this way the whole of the root of the penis liberated. Hæmorrhage gave but little trouble; certain branches of the pudic artery were of necessity divided, but there was no difficulty in securing these. A second incision was now made round the root of the penis, the suspensory ligament was divided, and then, by traction on the penis, and division of a few bands of connective tissue, the whole organ was removed through the second incision. Hamorrhage was then carefully arrested. The urethra was next split on either side, so as to form two flaps, and these were fixed by sutures to the sides of the perinæal opening, the object of this being to prevent stricturing of the new meatus. rest of the perinæal wound was sutured. The anterior wound, which it could be seen was separated from this by the whole depth of the scrotum, was sutured, except for a portion where a drainage tube was inserted. At a second operation the glands on each side were re-moved. As so frequently happens, the glands were found more extensive than at first sight appeared, and it was necessary on the right side to follow them up through the crural canal into the pelvis along the external iliac artery and along the deep surface of the obturator internus. On the left side, where the glands were apparently more enlarged, there seemed to be no pelvic involvement, but one of the glands was unfortunately broken in attempting to detach it from the fascia. This involved the risk of diffusion of the growth, and to obviate this the whole wound was sponged out with undiluted carbolic acid; this necessitated drainage, as such drastic treatment leads to the effusion of a good deal of serum, but the wound, none

the less, healed quite readily.

Mr. Edmunds remarked that the

Mr. Edmunds remarked that the operation he had done on the penis involves a smaller incision than when the whole scrotum is divided, without in any way diminishing the thoroughness of the operation. It is little, if anything, more difficult, as there is plenty of room for detaching the corpora cavernosa through the posterior incision.

The subsequent result was quite satisfactory; the progress of the case was uneventful.

#### TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, FEBRUARY 12TH, 1909.

The President, A. R. PARSONS, M.D., in the Chair.

TUMOUR OF THE BRAIN.

Dr. Bewley exhibited a specimen of a cerebral tumour. The patient, a railway guard, had five severe epileptiform fits at intervals between June and November, 1907. He also suffered frequently from a feeling of tingling in the left forearm and leg. He was admitted into hospital in November. While in hospital the man complained of attacks of a tingling feeling in his left side, which was relieved by severe rubbing. He once got in hospital an epileptiform fit, beginning in the left arm. He never had a headache throughout, which was extraordinary. He never vomited once. He had no optic neuritis. Still, they could not help thinking that there must be a brain tumour on the right side of the brain, and from the frequency and pronounced nature of the attacks they thought it a cortical lesion, but the evidence in favour of localisation was not great. Knee-jerks were absent. There was no paralysis; he could walk very well, and was apparently in good health. He was admitted to hospital on November 14th, and went home for Christmas on December 24th. Four weeks afterwards he returned a good deal worse. There was almost complete paralysis of the left arm, and incomplete paralysis of the left leg, anæsthesia of the left arm and leg, and great drowsiness. The left side of the face was slightly paralysed. The drowsiness continued and merged into coma, and he died on February 11th comatose. Dr. Bewley hardened the brain by a method suggested by Dr. Leeper. He passed a large aspirating needle through the orbit and back into the sub-dural space, and through it poured in a quantity of formalin. The brain preserved its shape exceedingly well, and the sections exhibited showed the tumour clearly. The suspicion that it was a cortical lesion was not correct. It was an infiltrating glioma, and was interesting from the absence of the three cardinal signs of tumour and from the history of epileptiform seizures, and showed the difficulty of diagnosis in some cases of brain tumour.

Dr. LEEPER said the method to which Dr. Bewley had referred was taught to him by Professor Marie at Paris. He used it with satisfactory results in the case of insane persons who were a long time dying. He thought the epileptic seizures might have been due to multiple thrombosis. It was suggested that the blood of epileptics became more acid than normal, and that thrombi formed.

thrombi formed.

SEPTIC ENDOCARDITIS STARTING FROM CONGENITAL
PULMONARY NARROWING.

Dr. Bewley said the patient was a young man, aged thirty-two, who since childhood had been told that there was something wrong with one of the valves of his heart. He enjoyed good health until July or August last, when he began to suffer from chills and rigors. These recurred from time to time, and about September last he got some pleuritic trouble on his left side. When in Cork he suffered from pain in his right side, and Dr. Pearson, of Cork, found some

pleural trouble. He had a good deal of fever. Dr. Pearson found he had a loud systolic murmur heard all over the region of the heart, but specially loud over the second left costal cartilage. He thought he had a congenital narrowing of the pulmonary orifice. The patient was afterwards brought to Dublin and put under his care. He looked badly, and had some degree of irregular temperature. He has wasted a good deal. His liver was palpable, but seemed fairly natural in shape. A trace of albumin was present in the urine. He had a very slight cough. The diagnosis was not very clear. He (Dr. Bewley) thought it was probably general tuberculosis, but no tubercle bacilli were found on examination. possibility was that there was a concealed focus of of septic endocarditis. He did not himself think so, as there was no sign of emboli in the body. The patient became gradually weaker, and died in ten days. When the heart was removed he noticed that the two ventricles had approximately the same thickness in the muscular walls. The tricuspid orifice was slightly smaller than one would expect, and rather smaller than the mitral orifice. In the right ventricle he found a constriction about an inch and a half below the pulmonary valve. When they opened the pulmonary artery they found, starting from the constriction and growing up to the valves, which looked fairly healthy an anamous was a second to the starting from the constraints are constraints. fairly healthy, an enormous mass of vegetations. There was also a small opening in the septum between the ventricles. The left side of the heart and the aorta were perfectly healthy. They found scattered through the lungs a great many masses of infarcts surrounded by zones of inflammation; one or two were breaking down into little cavities. The diagnosis was a slow form of septic endocarditis, grafted on a congenital narrowing of the right ventricle just below the pulmonary orifice.

The Secretary said the sections of the vegetations under the microscope were crowded with microorganisms. There were present a diplococcus and a gram-staining bacillus. Inoculations from a very mixed culture-tube made from one of the infarcts killed two rabbits in the course of a few hours. He recovered two organisms from the animals. He was almost certain that the diplococcus was the pneumococcus, but he did not yet know what the bacillus was.

Dr. KILPATRICK asked if any attempt had been made to recover organisms during the patient's life.

Dr. Harvey asked if Dr. Bewley had any theory to account for the vegetations occurring on the right side of the heart, which might throw some light on the vexed question of why vegetations usually occurred on the left side. Did he think it was due to the extra force of the blood coming through, or had it anything to do with the aeration of the blood being altered by the communications between the auricles and ventricles?

The PRESIDENT asked if there was any evidence of infection of the general systemic circulation?

Dr. Bewley, in reply, said he only had charge of the case ten days, and during that time the patient was obviously dying. He could not find bacilli in the sputum, and he did not get any examination of the blood made. The condition might have been due to some roughness about the constriction and the increased force. He did not think there was any change of aeration. The pressure on both sides was probably much the same, so that there was evidently no free flow of blood between the two sides. All the other organs were healthy; he did not examine the brain. There was no trace of sepsis except in the lungs.

DUODENAL ULCER.

Dr. James Little exhibited a specimen. The patient was of the age, about sixty, when duodenal ulcers were, in his experience, most frequently seen, and he thought that nearly all he had seen had been in men, and he had seen more in private than in hospital practice. The man was well nourished and healthy-looking, but for five or six months he had been subject to abdominal pain which was in proportion to the solidity of the food he took. The pain

was rather to the right of the umbilicus. About ten days before admission to hospital he had two bleedings from the bowels, but he did not seem to think himself very ill. After three or four days in hospital he passed the half-full of a chamber vessel of hospital he passed the hair-full of a chamber vessel of bright-coloured blood, which looked as if it had come from the intestine not very far up. No trouble was found, however, in the rectum or descending colon. He had a further bleeding, and later he suddenly vonited for the first time a large amount of blood. On the same evening he had another large hæmorrhage, and died an hour or two afterwards. At the post-mortem they found a duodenal ulcer, and the cause of death was the rupture of an artery in the floor of the ulcer, which really was the head of the pancreas. He had never before seen death under the same circumstances. There was a second ulcer in the

The PRESIDENT asked if the man had exhibited any

symptoms of hunger-pain?

Mr. Wheeler said he had had five cases recently; one was verified by post-mortem and four by operation. All were past middle life, but none of the age of sixty. In four out of five duodenal ulcer was diagnosed chiefly on account of the hunger-pain which came on generally on the right side about four hours after food, and was relieved by eating something. Vomiting was irregular, and had no relation to food. In the fifth case the ulcer had perforated when the abdomen was opened, and was not diagnosed; the duodenum was practically rotten and leaking.

Mr. Stokes said Mayo found that 69 per cent. of

ulcers were duodenal, and in males the proportion was still higher. Gastric ulcer was rather commoner in females. The hunger-pain was found in any lesion

of the middle gut.

Dr. Moorhead said that in two cases of duodenal ulcer he had seen, one in a woman, aged fifty, the typical hunger-pain was present. The ulcer was found by operation, and a complete cure effected. The other case was a young man, aged twenty-two, who never had the hunger-pain. He had symptoms of perforation, and a perforated duodenal ulcer was found on

Dr. CAHILL said the age-limit was probably the final crisis after a chronic trouble of many years, so final crisis after a chronic trouble of many years, so that duodenal ulcer began much earlier than was usually thought. The hunger-pain was found in several other conditions. A definite time-relation could be found by giving the patient something indigestible, like pork, to delay the pain.

Dr. LITTLE, in reply, said he had no doubt that the hunger-pain was clinically important, but it was certain that it was not so pathognomonic as it was supposed to be

supposed to be.

TUMOUR OF BRAIN.

Dr. LITTLE also exhibited a specimen of cerebral tumour taken from a girl, seventeen years of age. She had come to hospital about ten days ago, having sickened and vomited on the Friday previous to the Tuesday on which she was admitted. On the Sunday she became unconscious. She was unconscious on admission, and appeared to have paralysis of both sides of the body. She had very strongly contracted pupils, and, remembering a similar circumstance in a case many years ago, he made a diagnosis of a pons lesion. He made a post-mortem, and in the centre of the pons he found a hæmorrhage as big as a marrowfat pea.

Professor Scott said it was a pure hæmorrhage, but not of an ordinary type. Nearly every artery appeared to have weakened walls, and the apparent tumour was made up of innumerable discrete hæmorrhages.

STENOSIS OF TRICUSPID AND MITRAL ORIFICES.

Dr. Coleman exhibited a heart with stenosis of tricuspid and mitral orifices. The patient was a girl about twenty-four. She had a history of attacks of rheumatic fever. She was admitted to hospital about six months ago, and died in five months. The prominent symptoms were dyspnœa, cyanosis, and some cedema, and two or three weeks before she died she had embolism of the right femoral artery, and in the case of the brachial artery the nutrition of the

limb was retained, but she got gangrene up to the knee in the right leg, and amputation was performed. He diagnosed mitral stenosis from the physical symptoms. An unusual point was that the presystolic murmur was heard over a more extensive area than usual. A thrill was present, but only over the mitral area. She was found at the post-mortem to have well-marked mitral stenosis. The mitral orifice was reduced to a mere slit, and she had considerable stenosis of the tricuspid. In addition she had recent vegetations on the aortic cusps.

Dr. Bewley and Dr. Little recalled similar cases.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD AT THE STAFFORD ROOMS ON FEB. 18TH, 1909.

DR. E. GRAHAM LITTLE read a paper on "Ionisation in the Treatment of Skin Diseases," a full abstract of which will be found on page 244 of our present issue.

Dr. LANGMEAD read a paper on "Infant Feeding by Undiluted Citrated Milk," which is published in full

on another page (see page 241).

The following members took part in the discussion:

Sir Almroth Wright, Dr. Davis, Dr. Willcox, Dr.

Miller, Dr. Payne, Dr. Turtle, Dr. Finny, and Mr.

Laming Evans.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD FEBRUARY 25TH, 1909.

The President, T. H. BICKERTON, in the Chair.

THE PRESIDENT referred to the loss to the Institution by the recent deaths of Prof. D. J. Hamilton, of Aberdeen; Drs. G. E. Walker and J. Tawse Nisbet, of deen; Dis. O. E. Walket and Liverpool; and Dr. H. W. King, of Chester; and expressed sympathy with their families.

Mr. R. C. Dun read a note on

THREE CASES OF CONGENITAL RECESSES OF THE LOWER LIP.

The condition in each case was associated with double hare-lip and cleft palate. No family histories of congenital deformities could be ascertained, nor were any other children of the families afflicted.

Case 1.—Two symmetrically placed recesses were present on either side of the middle line of the lower lip, which was thickened and everted. From them sinuses ran downwards in the substance of the lip, ending blindly under the mucous membrane on its inner aspect. The sinuses discharged a mucous secretion.

CASE 2 .- A similar condition was present, but with, in addition, papillæ at the orifices of the sinuses. Movements of protrusion and retraction were seen in

CASE 3 was most unusual, only one similar having been previously reported. Instead of two sinuses, there was present a single slot-like cavity in the lower lip. I in. in length, and I in. in depth. This child lip, 1 in. in length, and 1 in. in depth. This child also showed a deformity consisting of a fold of mucous membrane passing from the inner aspect of the lower lip close to the angle of the mouth on either side, to be attached to the alveolar margin of the upper jaw. Misplaced testis and torsion of the penis were also present in this case.

Mr. Dun reviewed the various theories which had been advanced to explain the presence of congenital diseases of the lower lip. None of them would adequately account for the mode of origin of the three different types of the deformity which had been met with. The condition was a rare one, only 38 cases having been previously reported. The note was illus-

trated by lantern slides.

Mr. Frank Jeans mentioned a case of congenital depressions, fistulæ in the helix. In the case of the auricle these potential dermoids had a definite developmental explanation.

The note was also discussed by Mr. R. W. Murray and Dr. Blair Bell.

Dr. Briggs read a paper on the SPONTANEOUS RUPTURE OF CYST-ADENOMATOUS OVARIAN TUMOURS,

in which he urged (1) that the primary cause of cyst rupture in cases of ovarian cyst-adenoma, is tumour degeneration (necrosis); (2) that the rarity of cyst rupture in relation to the frequency of tumour degeneration is not inconsistent with the adequate, vascular compensation almost invariably supplied by adhesions to the degenerated tumour; and (3) that

these adhesions are simply reparative, and are not, as generally stated, the result of peritonitis.

The innocent leakage through attenuated and thin cyst walls as a common and normal occurrence is excluded from the rare rupture: on the absence in the former, or on the presence in the latter of clinical

manifestations is based a working distinction.

Cyst rupture as an appreciable clinical and pathological complication is one of the accidents in a case of an ovarian cystic tumour, and just as in a case of accidental hæmorrhage during pregnancy, trauma or violence in the history of its causation is almost invariably wanting.

From the earlier and darker days of ovariotomy the records of 66 and 80 tappings of an ovarian cyst leave no doubt as to the healing power of the normal cyst wall.

He quoted, from Meredith and Spencer Wells, evidence as to the vital activity and resistance of the peritoneum and to the absence of adhesions after tap-

Where there are neither infective organisms nor loose particles of growth capable of implantation, he argued that intra-peritoneal cyst rupture—at the time unattended by serious hæmorrhage—is of itself a harmless, or almost harmless, pathological process. On the other hand, degeneration of the cyst produces a permanent opening, and a continuous dribble of cyst contents without any barrier of defence such as is provided by the hæmatocele sac around a chronic tubal

drip in a case of tubal mole.

Where adhesions are universal around both innocent and malignant tumours, and after torsion of the pedicle, hydroperitoneum is invariably absent, and rupture is counteracted.

Dr. Briggs also narrated four cases of cyst rupture which occurred in his own practice, and submitted the following brief analysis from them:—In non-malignant following brief analysis from them:—In non-mangnant cyst-adenomata the clinical manifestations are (a) of tumour degeneration: (1) impairment of health disproportionate to the size of the tumour; (2) abdominal pain; (3) variable distension of the abdomen; (4) irritability of the bladder (5) irregular menstruation, subject to the usual modifications of pregnancy, lacting and the climateric. (b) Of runture of the cyst: tation and the climacteric. (b) Of rupture of the cyst: acute pain; recurrent pain; vomiting; the accumulation, at a variable rate, of free fluid in the abdomen.

The diagnosis of cyst rupture by free intra-peritoneal fluid can only be (1) Positive, when the partially filled cyst can be felt, or when the previously firm cyst has completely collapsed; (2) presumptive, when the clinical manifestations of degeneration and rupture have been obtained; and (3) occasionally and exceptionally, when the free fluid is small in quantity and the gustive minutes both many cases. and the rupture minute; both may escape detection before and during the operation of ovariotomy. The modern preference for removal of the tumour entire, if practicable, accounts for a long incision in Case 4, whereby both the 20 oz. of free intra-peritoneal mucoid fluid and the dribble through the small aper-

ture of rupture were exposed to view.

The teaching of Matthews Duncan that, although the diagnosis of an ovarian tumour approaches practical certainty, it is not one of scientific precision, applies also to the recognition of complications.

The ovarian tumours of small size and the largest of only moderate size in his series of ruptured cysts had impaired the health of the patients to extents unusual for the size of each growth. Not one was malignant. The general peritoneum, so far as it was visible, was only changed in one—Case 1—in which it was injected and thickened, but not shreddy.
Finally, Dr. Briggs compared the mechanical influ-

ence, the loss of fluid, and the degenerative changes

in ovarian growths to their respective effects upon the general nutrition of the patient.

He argued that the benefits the patient often experienced during temporary recumbent rest were more consistent with degenerative changes than with progressive tumour growth in cases where inflammatory complications were absent.

The paper was illustrated by lantern slides and specimens.

The paper was discussed by Dr. BLAIR BELL. He had operated on two cases. He thought diagnosis should be easy, and prognosis good. He regarded it as a rare condition. Degeneration of the cyst wall, traumatism, or violent exertion might produce it.

"KISSING THE BOOK."

Dr. F. W. LownDES read a paper on "Kissing the Book." He gave personal recollections of 43 years' experience in various judicial courts. He gave instances of the insanitary and dangerous nature of the English. method of taking the oath, which had been clearly proved to have caused disease in two cases, while this was only an infinitesimal proportion of the real number which it would be very difficult to trace. He urged the abolition of the use of the "Book" and the substitution of the uplifted hand.

While discussing the paper, the PRESIDENT proposed the following resolution:—"That this meeting is of the opinion that the custom of kissing the Book on taking an oath is insanitary and dangerous, and should be abolished, and the form of administering the oath with uplifted hand be adopted."

The resolution was seconded by Mr. R. W. MURRAY. and carried unanimously.

The paper was also discussed by Drs. Gill, T. R. Bradshaw, F. Barendt, A. G. Gullan, Sullivan, and W. B. Warrington, and Mr. Damer Harrisson.

Dr. Lowndes replied.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MARCH 5TH, 1909.

Dr. RUTHERFURD in the Chair.

THE members were treated to a very extensive exhibit of specimens of diseased conditions.

Dr. W. K. HUNTER read notes of a fatal case of leukæmia in a child, 5 weeks old. The liver and spleen were greatly enlarged, and the blood had undergone serious changes, there being a great increase of mono-nuclear leucocytes, while the red blood corpuscles were greatly reduced in number, varied greatly in size and in staining power.

Dr. MUNRO KERR showed a large tumour of the kidney (hypernephroma), removed by abdominal route. He also showed an interesting specimen of cancer of the sigmoid, removed with the rectum by the combined abdominal and perinæal routes.

Sir George Beatson exhibited a beautiful series of colour drawings illustrating types of diseased appendix, some with stricture, concretion, etc.

Dr. T. K. DALZIEL showed a man on whom he had performed a brilliant operation for malignant disease of the tongue and pharynx. Most of the tongue had been excised, with one tonsil, the corresponding pillars of the fauces, and part of the pharynx. All the glands below the jaw were taken away; and in a second operation Dr. Dalziel completed his successful operation by removing the rest of the cervical glands down to the clavicles. A tracheotomy tube was used as part of the technique of the operation.

Interesting specimens were exhibited by Dr. Archibald Young, Dr. John H. Teacher, Dr. Pringle, and others.

GLASGOW EASTERN MEDICAL SOCIETY.

MEETING HELD MARCH 3RD, 1909.

The President, Dr. MATHIE, in the Chair.

A VERY interesting lecture, "Demonstration on Some

of the Enlargements of the Kidney, with Reference to Diagnosis," was given by Dr. John Anderson, Pathologist to the Victoria Infirmary. Dr. Anderson referred to three lines that were useful for diagnostic purposes. These were: Gairdner's line—a line drawn from the left axilla to the umbilicus. Normally there should be resonant percussion in this line. In marked enlargements of the spleen there would probably be dull percussion advancing across Gairdner's line. A more useful line, according to Dr. Anderson, was Litten's line—a line drawn from the sterno-clavicular articulation to the tip of the 11th rib. The normal splenic dulness was posterior to this line, and any decided enlargement of the spleen would cross this boundary and give rise to dull percussion. Another useful line was Addison's—namely, a line encircling the body mid-way between the supra-sternal notch and symphysis pubis. Dr. Anderson pointed out that one-flird of the kidney lies above Addison's line, and that the pancreas and the duodenum have a definite relation to the line. He stated that normally the supra-renal capsules have an inward inclination.

Among the specimens exhibited were cancer of the kidney, tuberculosis of the kidney, hydro-nephrosis, and cystic disease of the kidneys. In congenital cystic disease of the kidneys the organs may reach a large size, and the patient live on to middle life, be unaware

of his disease, and die of uræmia.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

#### FRANCE.

Paris, March 7th, 1909. EAR-RINGS.

THE desire to adorn the face by means of objects of gold and silver, appended to the ears, dates, it would appear, from the highest antiquity. Ear-rings or pendants have been found in nearly every sepulchre; those of the bronze age were distinguished by the size and weight of the rings.

Among certain peoples, ear-rings were used as a means to give a certain form to the organ to which they were appended. The Chinese, for instance, pierce the ears to suspend heavy objects in order to render them long and pendant. The inhabitants of Laos make the long and pendant. The limitabilities of Labs make the hole so large that one or two fingers can be passed through it. The Omagnas carried a bouquet of flowers in their ears, thus perforated.

Beauty is, after all, purely conventional, and, as regards the ears, we can ill afford to criticise, we who

without knowing very well the reason why, cut dogs tails short or leave them long, as fancy seizes us to obey some æsthetic whim which varies with the race of the canine species.

From a medical point of view the wearing of earrings, as well as the preliminary piercing of these organs, can provoke accidents or maladies.

Dr. Lucas-Championniere published different cases in which the modern screw button produced disorders rendering an operation necessary. Dr. Nicolas relates the case of a distinguished young lady in whom a diamond solitaire screwed into the lobe of the ear had produced inflammation of the region, and was buried in the tissue. An incision was necessary to extract the solitaire, and the parts took a month to get well.

Affections following the little operation of piercing the lobe have been frequently reported. The majority of these accidents are benign, and belong to the group of cutaneous maladies, but others, on the contrary, may be grave and result, as has been more than once noticed, from inoculation of tuberculosis or syphilis.

According to Dr. Leon Perrin, impetigo, among the

skin diseases, is the most frequently observed. Pustules form around the perforation, which, by successive inoculations, may spread to the face, neck, or head. Cervical adenitis or otitis of the middle ear may even complicate the situation.

Eczema is also observed from perforation of the lobes in children, with seborrhæa of the head. It persists a long time, and may invade the face.

Constantin Paul says that he was struck with the fact that such a slight traumatism could give rise to phenomena inherent to the constitution of the child or the adult. He himself pierced, with all the desired precautions, the ears of a young girl of his own family who up to then apparently enjoyed the best of health. Yet afterwards the little wound provoked a crop of herpes which returned every year.

Cheloids of the lobe have been observed by several authors. Perrin cites a case of a cheloid situated behind the lobe, and which at the end of the year acquired the size of a nut.

Fournier and Chaunau recently reported a series of accidents due to the piercing of the ears, among which may be mentioned erysipelas, gangrene, and inflammation of the mouth.

Leloir observed a case of tuberculous lupus in a young girl of twenty. It began shortly after a jeweller of the town had pierced the ears of the patient. Hitherto the young girl was of an excellent constitu-tion, and none of her family suffered from tuberculosis, but the jeweller who performed the operation was phthisical, and died of that malady.

Prof. Unna, of Vienna, relates a particularly grave case of contagion: A young girl, æt. 14, of a perfectly healthy family, wore earrings which belonged to a healthy family, wore earrings which belonged to a friend who had died a short time before from consumpton. Some months afterwards the girl fell ill; ulceration appeared on the lobes of the ears; the glands of the neck became engorged, while the presence of tuberculous bacilli was observed in the granulation of the auricular ulceration. Bronchitis set in, and the patient rapidly succumbed to tuberculosis. Barthelemy relates a similar case.

Even syphilis has been proved to have been contracted from this operation. Prof. Fournier related four typical cases in his work on syphilis. Dr. Le Ray reported, some years ago, a case of a young girl of ten who presented mucous patches in the throat and the characteristic eruption on the body as a result of contamination through the trocar of a jeweller who had the disease.

The knowledge of these different accidents-cutaneous, tuberculous, or syphilitic—should inspire, says Dr. Muller, certain prophylactic measures. The jewellers should be forbidden the right of piercing ears, or at least they should be warned of the danger to which they expose the child by employing septic instruments or using the same instrument indiscrimi-nately for a number of children, some of whom might

be suffering from contagious affections.

The operation should not be practised except between the age of 12 and 25 years, the production of eczema and impetigo being very easy in young children.

Abstention should be preferred in scrofulous or lymphatic children, for fear of lupus or tuberculosis.

The best prevention, need it be said, would be to banish this useless custom for ever. Our grandmothers had some excuse; they believed that the wearing of pendants, sleepers, and rings preserved the children from maladies of the eyes. To-day faith in this intervention is lost except in certain countries, where even the men wear little gold rings in their ears.

The Greeks and Romans, good judges of feminine

beauty, did not esteem the ear-ring indispensable to it. The brushes or chisels of the immortal Greek artists did not represent any paintings or statues with ear pendants.

On the other hand, these pendants were inflicted by the Romans on the vanquished as a mark of servitude. COLLOIDAL METALS.

The action of colloidal metals on local infections and diseases of nutrition has been proved to satisfaction.

Albert Robin observed that pneumonia is the disease in which the treatment by colloids appears to be particularly indicated, as it provokes all the phenomena of reaction; it diminishes notably the duration of the malady and at the same time the mortality. The brilliant success obtained by intra-rachidian injection of collargol in cerebro-spinal meningitis has not been forgotten. These injections were attempted for the first time by MM. Caussade and Joltram. M. Rosenthal and Mile. Joffe cured an inveterate drunkard suffering from cerebral rheumatism by injections of electrargol. Numerous have been the cures of peritonitis, general or puerperal, by injections of colloid silver. Dr. Massin, of Nice, employs with success injections of electrargol for purulent otitis. To this list might be added affections of the urinary passages, pleurisy, phlebitis, etc.

GRRMANY.

Berlin, March 7th, 1909.

Herr Busc At the Freie Vereinigung der Chirurgen Herr Busch said that during the last four years at the surgical department of the Urban Hospital he had met with 22 cases of sudden death from cardiac disease. Twelve of these took place so rapidly that there could be no question of any operative procedure, such as had been proposed by Trendelenburg. In the remaining ten the period of time between the commencement of the attack and death varied from ten minutes to three hours, the average being 30 minutes. The autopsies showed that there was pulmonary embolism in only five cases, in the others the grave form of myocarditis was present, or brown atrophy of the heart. Clini-cally these cases were not distinguishable from the other five, so that a diagnosis of pulmonary embolism was at the least very uncertain. At the autopsy on the case that lived longest Körte performed an operation exactly according to the directions of Trendelenburg. At it he removed a thrombus, which, however, was a cadaveric one, whilst the whole mass of that that had formed during life remained behind in the vessels.

Herr Körte pointed out that of the cases that had to be diagnosed as embolism of the pulmonary artery many pulled through with difficulty, so that it was extraordinarily puzzling to fix upon the exact

indication for operation.

Herr Körte said that during four years he had performed 152 choledochotomies in a total of 237 gall-stone operations, most of them complicated with cholecystectomy. One was a case of carcinoma of the papilla Vateri, that had been operated on two and a half years earlier, and in spite of the bad prognosis in these cases the patient recovered and remained free from recurrence. The classical symptoms of biliary colic were by no means always present: jaundice, colic, small contracted gall-bladder. Jaundice was absent in 25 per cent. of the cases, and on the other hand jaundice and acholia of the stools were present without stones in the duct. Colic also might be absent, then there were only attacks of fever with great prostration, and slight jaundice. It was just in these cases that operation should not be long delayed, or it did no good. The gall-bladder also was not always contracted. Even in case of a large gall-bladder, a careful inspection of the bile passages was indispensable.

In a total of 142 gall-duct operations he had had five deaths: 3.5 per cent. If to these were added 10 cases in which there were complications, there was a total of 152 cases with 8 deaths: 5.2 per cent.

He had laid down the principle never to approach these cases with his mind made up, but to follow up the whole biliary system, and search for the calculi

in whatever corner they were secreted.

After a paper on umbilical hernia by Hr. Ruge, After a paper on umbineal nernia by Hr. Ruge, Hr. Brentano showed a young woman, æt. 24, whose rectum he had resected for a space of 27 cm., for papilloma; she had suffered from hæmorrhage and mucous discharges from the bowel. In spite of the extent of the removal, some polypi still remained, an experience that again taught how little surgery could do in these cases. could do in these cases.

A girl, æt. 19, had tracheotomy performed on account of severe dyspnæa; even before this a tumour below the vocal cord had been diagnosed, the mucous membrane over it being intact. Five days after the tracheotomy the larynx and cricoid cartilage were split, and the tumour removed. It proved to be an intratracheal struma.

A man of middle age was taken ill with abdominal A man of middle age was taken ill with abdominal pains, particularly in the upper part, collapse and symptoms of peritonitis. The speaker decided that the case was one of acute pancreatitis, and he was confirmed in this opinion by a distinct resistance appearing in the course of a few days, in the bulging epigastrium. He made an incision in the median line, as well as counter incisions in both flanks, and obtained a large quantity of chocolate-coloured fluid, but no fat necroses. For a long time pancreatic juice but no fat necroses. For a long time pancreatic juice emptied out of the wound, transient sugar was found in the urine. Of six similar cases that he had operated on four had recovered.

### AUSTRIA. Vienna, March 7th, 1909.

ATTIC CHOLESTEATOMA.

At the Gesellschaft der Aerzte, Barany presented a woman, æt. 30, from whom he had repeatedly removed cholesteatoma and polypi from the middle ear. The difficulty of removing these from the antrum while endeavouring to retain the epidermis covering the stapes and hammer was finally accomplished, but, unhappily, was followed by the formation of a granuloma over the stapes, which had to be removed, and left a rent in the tympanum. After this the patient suffered from vertigo with fistula of the labyrinth, as the typical rotatory nystagmus of both eyes was painfully present. That fistular symptom has now disappeared, and the open wound over the stapes quite closed up.

The peculiarity in this case was the wonderful functional result, the hearing being as good now as ever, after so much damage to the tympanum and

injury done to the stapes and hammer.

LYMPHANGIOMA OF ORBIT.

Bergmeister next exhibited a child, set. 23, with a thick upper left lid, due apparently to an ill-defined soft swelling extending under the skin to the temporal region. The swelling was somewhat compressible, but not affected by that to-and-fro movement by compressing the jugular. The bulbus of the eye was not protruding, but, on the contrary, was sunken in the socket. The fundus of both eyes was perfectly normal. In addition to this, there were a number of pigmentary patches over the breast and back.

According to the theory propounded by Recklinghausen, this is the first symptom of neuro-fibromatosis in the cutaneous nerves. This neuro-fibroma, sometimes known as Ranken's neuroma, is difficult to distinguish clinically from lymphangioma, as both are

depending on the same anatomical process.

LYMPHO-SARCOMATOSIS.

Siegfried brought forward an old man, æt. 74, suffering from a diffuse, reddish-blue erythema covering the head, among the hair, neck, and body, as low as the breast, where it formed a sort of arc between the mammillæ. At first it was recognised as a lichenoid exanthema, till closer observation of the cedema, which was very insignificant, the coold, confluent efflorescence, itching, and localisation of parallel nodules attracted attention. Further examination revealed large hard glands in the supra-clavicular region on both sides of the body in the axilla, as well as hard, cedematous skin on the left side of the thorax.

The cause of the false diagnosis was due to the bilateral presence of the morbid change, which is a rare condition in lympho-sarcoma, though common enough

in lichenoid dermatosis.

CONTRACTION OF SECOND PHALANX.

Lotheissen showed a patient on whom he had operated for contraction of both little fingers, which became stiff about the eleventh year of age without any apparent cause. He first made an N-incision, dividing the skin over the muscula interossei and lumbricales, forming two triangular flaps. Having done this, he found the finger could not be straightened. He next resolved to divide both angles of the aponeurosis, which in this case was much wider, but shorter than the

normal, and thus relieved the contraction. He considered this equal to Dupuytren's contraction of the palmar aponeurosis, which appears to have originated in a chronic plastic inflammation. The patient is now able to move his fingers freely both in extension and contraction. He considered the operation necessary in these cases when the deformity interfered with work

Klein thought many of these contractions were hereditary, like retinitis pigmentosa, which had always a family history. Tandler remarked that these cases of contraction of the little fingers were not uncommon if the statistics of the post-mortem room are to be credited. He has frequently met with it, and agrees with Lotheissen that the deformity is due to the aponeurosis being shortened, which prevents the proper extension of the fingers.

Schlesinger said that he had seen contractions in the little fingers for three generations in one family history. The rule was an abnormal shortening of the fingers and a shrinkage of the phalanges.

COPPER SULPHATE POISONING.

Pollak showed a female, æt. 20, who had attempted to poison herself by drinking a solution of 10 grains of sulphate of copper. Severe vomiting of a blue fluid followed. The stomach was washed out, but soon after this icterus, somnolescence, severe pain in the epigastrium and region of the liver, with anæmia of the mucous membrane, albumin, and blood in the urine, set in. Great anæmia was present after the icterus had disappeared, but a few days later the patient returned to her normal condition.

#### HUNGARY.

Budapest, March 6th, 1909. At the recent meeting of the Budapest Royal Medical Society, Dr. Balint read a paper on FUNCTIONAL RENAL DIAGNOSIS.

He said that opinions are still very much divided concerning cystoscopic renal diagnosis, and enthusiastic reports alternate with more conservative articles. Dr. Balint's paper belongs to the latter class, for he had some experiences which make him doubt that absolute reliance in the method is safe. The character of the food and the amount of fluid ingested seem to have a marked influence upon the freezing point, but even if the diet is simple and absolutely uniform the figures vary within very wide limits. Several cases are reported, he continued, where the wrong kidney would have been extirpated, if the molecular concentration alone had been taken into consideration. Much more satisfactory results are obtained if attention is also paid to the daily amount of urine and if renal activity is expressed in so many daily molecules. In all cases the diet should be controlled, and the catheters should be introduced a definite period after a meal and left in position for at least two to three hours, since fluctuations are very common. At best the method is only approximate, but though troublesome, it offers valuable aid in conjunction with other data.

Dr. Sellei discussed the
Value of X-Rays in Circumscribed Peri-urethral
Gonorrhæa.

The utility of the X-rays, he said, as a diagnostic
agent in urology is well recognised. Therapeutically, however, in the diseases common to this special branch of medicine, they have made but limited progress. Sellei described the *technique* at Budapest in three cases of peri-urethral infiltration. The intensity of the current was three to four ampères. The tubes were No. 3, and moderately hard. The exposure period was ten to fifteen minutes. In the first exposure a piece of sheet lead was used (as done by Kaufmann however, in the diseases common to this special branch a piece of sheet lead was used (as done by Kaufmann in Frankfort) to shut off the parts intended to be protected. Later, however, a lead cylinder was used. The distance from the tube varied from 10 to 20 cc. Sellei reported from three cases in detail. They were each of cavernous infiltration, which had resisted ordinary forms of treatment. He does not claim that the rays are a panacea in the treatment of this condition or even that they destroy bacterial life. It is apparent that they are a very decided factor for good,

however they may work, whether by direct destruction of the bacteria or by causing the absorption of the inflammatory tissues. Three cases are not sufficient upon which to base any conclusions, but it would appear that the disorder is sufficiently superficial to lend itself favourably to this form of therapy. INFLUENCE OF WEATHER CONDITIONS ON MORTALPTY.

According to the bulletin of the Health Department for the month ending December 31st, the influence of the weather conditions of the last three weeks (in December) is already being reflected in the bills of mortality. The death-rate for the month is 12.5 per cent. higher than that of the previous month, and previous ten years. An analysis of the figures in the statement of mortality indicates clearly that the weather and exposure to it at outdoor sports, in Christmas shopping, at skating, is made responsible for the increase. Owing to the incidental tramway strike, deaths in consequence of fractures, etc., were on the increase. Thus, there is a 12 per cent. increase in the deaths among the aged—those over sixty years. Deaths from the chronic diseases show increases of 10 per cent. each for consumption and heart diseases, of o per cent. for Bright's disease, 12 per cent. for cancer, and 60 per cent. for diseases of the nervous system. The death-rate may be expected to increase during the succeeding months, January and February, and therefore even the lay papers warn the public that "those suffering from common colds, catarrhs, and similar slight affections of the respiratory system all of which are almost epidemically prevalent, should exercise more care to prevent the development of tonsillitis, consumption, and pneumonia."

Dr. F. Fischer describes his experiments concern-

ing fatty degeneration in the Orvosok Lapja.

His experiments prove that fatty degeneration is not caused by an actual conversion of cellular protoplasm into a fat, but by deposit of fat from the circulation. A chemically pure soap was allowed to circulate through the kidney of a rabbit with glycerin, the animal then killed, and serial sections made of the hardened organ. The endothelial cells presented a finely granular appearance, while the tubular epithe-lium was in a condition of acute degeneration. With sudan all the granules were stained intensely, the fatty deposit being most marked in the convoluted tubules of first and second order, less so in the cells of Henle's loop. The tissues in the neighbourhood of vessels were most affected, especially where an artery and vein were present close together. The experiments are an evidence of active chemical changes in the cells as the soap was first split up and the fatty acids then combined with the glycerin to form which took the place of the altered cellular protoplasm.

EXTENSION OF THE POLYCLINIC HOSPITAL.

The annual meeting of the Polyclinic doctors held February 11th was signalised by the opening of new wards and private rooms, these being part of the extensive improvements made during the past eight months. The work of the Polyclinic is increasing that the clinics last very averaging to come delivered. months. The work of the Polyclinic is increasing yearly, the clinics last year averaging 103 cases daily, and 1,080 persons were admitted to the wards. In and 1,000 persons were admitted to the wards. In the accident wards over 3,000 cases were received. Three adjoining properties are owned by the Polyclinic Corporation, and on these an addition to the hospital will be erected as soon as £8,000 can be raised.

#### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### - SCOTLAND.

EDINBURGH ROYAL ASYLUM.-Dr. G. M. Robertson submitted his first annual report on the working of the institution to the meeting of the Corporation on February 22nd. The average number of patients resident was 733; 356 men and 377 women. During the last three years the admission rate has been falling off steadily owing to the opening of Bangour Asylum, and the admissions last year numbered 237, or 78 less than in the previous year. He dwelt on the advantage taken

of the accommodation at West House, where patients are admitted at a standard rate of £45 a year; on this department there is a loss of £3 per head owing to the generous way in which the managers provide comfortable quarters for the afflicted members of the middle class who possess only moderate means. The opening of Bangour Asylum has set free adequate space in West House for this class of patient. With regard to the character of the cases admitted, Dr. Robertson stated that 26 persons were diagnosed as alcoholic insanity, a percentage of 10.8, which compared favourably with the proportion of alcoholics in previous years. A more remarkable feature was that 11 persons were admitted suffering from post-influenzal insanity, being nearly 5 per cent. of the total admissions. The poison of the influenza germ had the most injurious effects on the brain and nervous system. As a rule, these effects were not immediate, as the poison acted by slowly impairing the nutrition of the nerve cells, and after the patient had been out of sorts for a fortnight, a month, or even more, the mechanism of some nervous function or another broke down. These nervous after-effects were legion, but fortunately only a few were permanent. The extent of the mental, physical, and material damage, indirect as well as direct, sustained by the nation as a result of influenza could only be realised by comparing it with that produced by excessive indulgence in alcohol. For one case sent to the asylum scores were incapacitated. The ill-health of these was a source of misery to themselves, and, if they were bread-winners, the diminution in their earnings was followed by as serious consequences for their families as would have been the case had the head of the family been a drunkard. An epidemic of cholera would have been less of a scourge to the country than these recurrent outbreaks of influenza. The percentage of recoveries was 31.3, which was the average for the asylum since 1900. Its lowness, as compared with the early years of the asylum's history, was due to the accumulation of senile patients, and to the small number of alcoholic cases (which recovered quickly). The total death-rate was absolutely and relatively low—6.5 per cent, of the total number under treatment. Dealing with changes in the establishment, Dr. Robertson paid a tribute to Dr. Clouston's superintendentship, and said that in Craig House Dr. Clouston had a worthy and appropriate memorial. Instead of having, as in the past, a matron on the ladies' side and a head attendant on the gentlemen's side, each performing similar duties and dividing the responsibilities for the nursing and domestic arrangements, a lady superintendent has been appointed in sole charge. It is no longer necessary, for safety's sake, as in the past, to restrict the care of male patients to men. The ladies' hospital at Craig House has been enlarged, and alterations have been made which will facilitate the use of open-air treat-

REGISTRATION OF NURSES IN SCOTLAND. — An influentially-attended meeting was held in Glasgow on February 27th, Lord Monclyde in the chair, in support of the movement for the establishment of a Registration Council in Scotland, separate from England. The Chairman said the meeting had been called in response to a circular from those who had drafted a Bill applicable to Scotland, in order to get a general expression of opinion on the matter. After careful perusal of the Draft Bill it seemed to him that it would be a retrograde step to hand over to a London Council the entire control of the training of Scottish nurses. The standard of the large Scottish training schools was very high, and there was no reason why it should be interfered with. The financial requirements of the English Bill would bear hardly on Scottish nurses. Dr. Mackintosh, Medical Superintendent of the Western Infirmary, gave the result of the plebiscile of Scottish nurses in favour of the establishment of a separate Registration Council in Scotland as follows:—Matrons and superintendents, 114; assistant matrons, 57; sisters, 218; charge nurses, 163; nurses in general hospitals 736; private nurses, 446; private nurses trained in special

hospitals, 35; total, 2,718. Miss Gill, Edinburgh, spoke against the London scheme, one of the objections being that Scotland was quite inadequately represented on the Board. Dr. Oswald, on behalf of mental nurses, said that of 22 medical superintendents, representing between 1,600 and 1,800 nurses, 18 were unreservedly in favour of a Scottish system of registration. The proposal was also supported by delegates representing general hospitals, Poor-law hospitals, provincial hospitals, asylums, fever hospitals, and the medical profession. Dr. Morton, Shelleston, favoured registration by a central body for the United Kingdom, and moved an amendment, but received only 7 votes. A committee was formed to carry on the movement for a separate Scottish Registration Council.

#### BELFAST

SEWAGE PURIFICATION.—The problem of the Belfast sewage and its disposal is still unsolved despite the expenditure of about £60,000 on various experimental works during the last ten or fifteen years. The latest experiments, which are only beginning, promise to be of great interest. They consist in the construction of of great interest. They consist in the construction of a series of Dibden slate beds, and last week Mr. Lionel Dibden, son of Mr. W. J. Dibden, the inventor of the system, came to Belfast and explained the working of the process at the beds, which are almost ready for use. The beds are formed of numerous ready for use. The beds are formed of numerous shelves of slate, one over the other, with spaces between, so as to give a large superficial area of slate for the sewage to come in contact with. The crude sewage is run into the beds and allowed to remain in contact with the slates for two hours, then run off. The slate beds take about two months to mature, and when mature apparently continue active an indefinite The maturing consists in the formation of a deposit of humus on the slates, containing bacteria deposit of humus on the states, containing bacteria and small worms, and by their action the crude sewage is purified quickly and without any objectionable odour. The beds are costly, as about 9,000 cubic yards of slate bed, containing 3,000 tons of slate, and costing £6,000, exclusive of structural work, would be required for every million gallons of daily dryweather flow of sewage. But, on the other hand, there is a saving of cost as compared with the sedimentation system, in there being no sludge to dispose of. The system is a most interesting one, and has favourably impressed many of the persons who have to deal with the difficult problem in Belfast, but owing to the cost being so great the committee of the Corporation still leans to the system of sedimentation and removal of the sludge by steamer.

PUBLIC HEALTH.—At the monthly meeting of the Corporation last week, it was reported that the death-rate from all causes was 17.9, as compared with 25.8 in the same period last year. Seven cases of cerebrospinal meningitis had been notified during the month.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

THE CENTRAL MIDWIVES BOARD AND SEPSIS RE VAGINAL EXAMINATIONS IN MIDWIFERY DURING LABOUR.

Io the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I am sorry to trouble you with another letter, but I desire briefly to explain that the contents of my former letter were not correctly quoted by your "Pathological" correspondent in your last week's issue. In support of his opinion he stated that the training of pupil-midwives under the rules of the Central Midwives Board will "encourage them to get into the habit of making vaginal examinations" in opposition to the best teaching of modern midwifery. Moreover, his experience leads him to doubt "whether it is possible according to my statement for a woman to gain by internal and external examinations a practical knowledge without risk to the patients." At the same time he accidentally omits any reference to the protective clause "that the practical training must

be carried on under the direct supervision of a registered medical practitioner or a certified midwife

appointed by the board for the purpose."

I feel confident that the criticism of your correspondent is the outcome of a sincere desire to promote spongent is the outcome or a sincere desire to promote aseptic treatment in every department of practice; and that he is stimulated by a profound hope—mingled with a little anxiety—that midwives will be trained to correctly carry out every precaution, and also to be ever ready to follow well defined regulations.

I am, Sir, yours truly,

JOHN WARD COUSINS.

Portsmouth, March 8th, 1909.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—"Obstetrician" says in his letter (see MED. PRESS AND CIRCULAR of February 24th, 1909, p. 197):-"To make vaginal examinations with satisfactory results, the nurse must acquire experience, and how can she do this unless she makes 'repeated vaginal examinations' during her training? It is far better she should make them then, when presumably under proper control and supervision, instead of after her training, when she is in a comparatively irresponsible position.

May I say that since I first began systematically to train ladies to be midwives and for district midwifery work in 1879, I always allowed them to sit with me while seeing the out-patients, and in this way they saw the gynæcological cases, learned the conditions in health and disease, not only of the os and cervix uteri, but of urethra and all the pudenda, of the

perinæum, rectum, etc.

From 1879 on we worked, before the L.O.S.—and subsequently the C.M.B.—came into existence, and our Board of Examiners testified to the excellent theoretical and practical efficiency of the students—a testimony amply corroborated by the splendid work done abroad in all those Eastern Countries where women only are allowed to see the women and their children, and minister to them medically. This plan we adopted at the very first, and carry on up to this day, and many of our students are skilled in use of catheter, speculum, etc., as well as in the use of midwifery instruments of different kinds. I had got so far when a lady missionary, on furlough from India, called on me to know if she might come to sit with me, and thus see some of our gynæcological practice, as it would be of such immense service on her return to her sphere of labour. She came because she had heard from some of our former ladies, trained in the first days of the Zenana Medical Mission College, and she bore good tidings of the work they were enabled to do in both gyngecological and midwifery cases. In the latter branch they now have so many calls they can only attend the difficult and operative cases, but, as they have trained some native women, our pupils are relieved by them from attendance upon all ordinary labours. Such an account, coming from students of those far-off days (for at first the natives would not have them at all till they had seen and heard of the good they had done in non-midwifery cases) is most encouraging.

I am, Sir, yours truly, G. DE G. GRIFFITH. London.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I do not know how to set about convincing "Pathological" of the necessity of teaching midwives both how to make vaginal examinations and how to obtain information from them, and if I try to do so I am afraid I shall repeat myself. However I will

try.

There are a number of points of vital importance which can only be learnt during labour by means of a vaginal examination, such for instance as prolapse of the cord, tumours of the bony pelvis or of the

appendages and fœtal monstrosities.

None of these things can be appreciated by the midwife unless she has gained a clear knowledge of the results of vaginal examination in the case of normal labour.

To gain this knowledge she must have made a number of vaginal examinations.

Vaginal examinations can not be made absolutely safe, but they can be made relatively safe by careful instruction, not alone in the nature of the danger but in the technique of the examination.

As soon as a midwife has acquired practical skill in the making of vaginal examinations the fewer she makes the better. While she is in statu pupillari, the few patients on whom she makes the examination have to suffer for the benefit of the many. Is it not always

so in the teaching of medicine?

Vaginal examinations are harmful, but they are vaginal examinations with the said of midwives. Both have been introduced to combat a greater evil, and this being so the best we can do with them is to render them as innocuous as possible, and to increase the service they render to the maximum.

The whole point is so obvious to me that I find a difficulty in understanding "Pathological's" point of view. Perhaps it would simplify matters if he will tell us what he advises under the circumstances, and not what he condemns.

I am, Sir, yours truly, OBSTETRICIAN.

#### OXYGEN IN SPORT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In his reply to my letter on "Oxygen in Sport," Dr. Leonard Hill is confusing the point at issue. He Dr. Leonard Hill is confusing the point at issue. He alludes to the use of oxygen twenty-five years ago by W. G. George, and refers to his own work in the Journal of Physiology. If Dr. Hill's researches were made before 1892 I ought, of course, when I wrote, to have known of them. If not, it is evident that I had previously demonstrated the fall of tension under torced avarges and its recovery by oxygen in the forced exercise, and its recovery by oxygen in the systemic arteries, and consequently in the left ventricle The sphygmograph may not be, as Dr. Hill remarks, an exact measurer of tension of the left heart, but it indicates its variations.

Dr. Hill to prove his case misquotes me as follows: "It (oxygen) does not restore wind at once by rendering the lung adequate to the extraordinary demand upon it." He goes on to say, "what I have ascertained is that oxygen inhalation affords a simple and powerful method of relieving the fatigue of the heart which follows extreme muscular effort, and that which follows extreme muscular effort, and that oxygen and exercise can be used as a valuable method of treatment." If Dr. Hill, who considers that my explanation of the action of oxygen is "wholly wrong," will kindly take the trouble to re-read my letter he will find that I gave long ago the same (the only possible) explanation as himself—the reverse of what he quotes me as saying. I demonstrated what he has since ascertained, that oxygen in restoring wind

what he quotes me as saying. I demonstrated what he has since ascertained, that oxygen in restoring wind did it by restoring the adequacy of the lung.

As regards oxygen and exercise (used simultaneously) being a valuable method of treatment, again Dr. Hill has discovered a plan pointed out by me at the time, and which I have frequently used in diseases of decreased oxidation, and also in the heart flag of morphinism due partly to the same cause. My modus operandi has been to associate the inhalation of oxygen with exercise on a home trainer, and I have often found it useful in these cases. In order, moreover, to protect myself from the accusation of copying future inventors I added in 1802, when I recommended this plan for gout and for other results of insufficient combustion, the following note to my article on "Oxygen in Sport": "Les inhalations d'oxygène ou d'ozone associées à l'exercice approprié, soit actif, soit passif, j'ose l'affirmer, deviendront le traitement par excellence Jose l'amrmer, deviendront le traitement par excellence de la goutte et de toutes les maladies à combustion insuffisante. Mais je ne fais que mentionner cette application ici pour prendre date et pour empêcher qu'on m'emprunte l'idée première de cette méthode."

I am, Sir, yours truly,

OSCAR JENNINGS, M.D. (Paris).

#### THE NAVY AND PROPHYLAXIS AGAINST SYPHILIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of March 3rd you refer to a question I asked the First Lord of the Admiralty, and his reply. This was with reference to the proposed syphilisation of all the men in the Navy as a precaution against syphilitic disease, and you say at the conclusion: "Any honest effort, however mistaken, to

onclusion: "Any nonest enort, nowever inistates, to prevent the gigantic evil, is deserving at least of respectful consideration."

With regard to that, I would say that there are perhaps different ways of showing "respectful consideration." One shows respect for a foe by shooting him; one shows respect for the devil by hating him and all his works. And that is the only way in which I could impairs any competent and thoughtful which I could imagine any competent and thoughtful statesman regarding the suggestion of Dr. Munimery. Surely, apart from the medical aspects of the case. every man who had to undergo the operation would be degraded. Surely the surgeons and doctors of the world have some character to maintain, and derive some advantage from the esteem of their fellow-creatures, which should not be lightly risked by pro-

Positions of this kind!

But to refer to the medical aspect of the case. Suppose, for the sake of argument, that the proposed operation did reduce the liability to contract the disease in a worse form, what evidence is there, what evidence could be obtained in a less time than thirty years, that the insertion of syphilitic pus from an anthropoid ape would not do far more harm than it did good? But the assumption that the process would have the desired effect is surely too large a one for have the desired effect is surely too large a one for any person accustomed to examine evidence to give it a "respectful consideration." Does the acquisition of the disease once render the diseased person free from any further attack of the disease? Is there any surgeon of experience prepared to answer that question in the affirmative? Does not Dr. Mummery's own paper contain ample evidence that the process which he suggests is quite unnecessary, and that any man of ordinary prudence and good conduct has nothing to fear from the hideous disease referred to, except it is from the lancet, poisoned in the manner that he would recommend?

I am, Sir, yours truly, ARNOLD LUPTON.

March 6th, 1909.

#### PAYING PATIENTS IN CHARITABLE HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR SIR,—I should be obliged if you could spare me space for the explanation of one point in your leading article "Private Patients in Charitable Hospitals."

You state that the Chairman "read from a circular ent to every applicant for attendance in the private

From this account your readers will form the opinion as did everybody present at the hospital meeting, and all those who read the accounts in the newspapers) that these circulars and regulations had existed to control abuse, whereas the fact was that no regula-tions whatever had existed, and no "circulars" either, until shortly before the meeting, and the week before the meeting they had not even been printed!

I did not know this at the time of the meeting, but when I learnt the fact, I addressed the two following questions to the Chairman, through the columns of the Liverpool Daily Post and Mercury:—

"(1) Is it a fact that the form and regulations which he read to the meeting had no existence before the last meeting of the Committee previous to the annual meeting; that these regulations were accepted and passed by the Committee at that meeting in view of the annual meeting; and that they were so recent that it would have been impossible two weeks ago to procure a copy in print?

"(2) Is it a fact that, previous to the adoption (less than one month ago, and after my recent correspondence, and in view of the annual meeting) of this specific form he read out, no such series of question or form for signature of any kind existed?"

The Secretary-Superintendent of the hospital was instructed to answer these questions, and—rather comically—while denying their truth, he stated that these regulations had been adopted on January 4thfive weeks to the day before the annual meeting.

Six months ago I had some private correspondence with the Chairman, and then informed him I should protest at the annual meeting. On November 28th and December 1st I had letters in the Post. During December the Medical Board drew up regulations for recommendation to the Committee, and at the meeting of the Committee on January 4th this form for private patients was accepted, but a recommendation made at the same time by the Medical Board that "the Medical Officer should be at liberty to charge fees for attendance upon occupants of the private wards" was rejected, the voting being 8 against, 4 not voting, and 1 in favour, and this one was the only member of the medical staff present!

.Considering the autocratic and offensive manner in which this same subject has been treated on several occasions previously by this Committee, I am pleased to have forced them to grant a small, though painful. concession to justice, and I trust that in some way sufficient pressure may be brought to bear to bring

them to their senses.

Private wards in charitable hospitals are essentially wrong, both to the charitable funds and the medical profession. They must be swept away. But, in the meantime, chairmen and committees such as exist at the Liverpool Southern Hospital must be compelled to abstain from working them so as to inflict the maximum possible injustice upon the medical profession. The recent discussion in the Liverpool press has done much to educate public opinion, and I am pleased to find that it has awakened a great expression of acknowledgment of the present injustice. I trust that the profession at large, and the medical press, will not allow the subject to drop, but help in every possible way to force an early reconsideration and readjustment of the relationship of the medical profession to medical relief.

I am, Sir, yours truly, CHARLES W. HAYWARD.

Liverpool.

THE NEWSPAPER PRESS AND QUACKERY. To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—My personal thanks are due to Dr. Oscar Jennings for his valuable letter published in your last issue. I have not a word of criticism to pass upon it—it is true and admirable throughout. I wish merely to make plain some of my views with regard to the proposed Royal Commission. But first I would like in parenthesis to point out that neither the like, in parenthesis, to point out that neither the General Medical Council, nor the Council of the British Medical Association has included the question of quack medicines in its proposals for a Commission. If this question be left out in any inquiry into the subject it will prove practically useless. Fraudulent quacks, finding the dodge by far the safest, are more and more carrying on practice under the cloak of the sale of nostrums and apparatus. They do not directly adopt medical titles, but employ fictitious doctors' names in their advertisements, and use language leading the simple public to believe that when in the hands of the quacks they are consulting duly qualified practitioners.

I look upon a Royal Commission as merely a means towards certain ends, not as an end in itself. In the first place, it would bring shame to newspaper proprietors, and force some of them to mend their ways. The number of papers that make any effort to cleanse their pages from fraudulent quack advertisements is rapidly diminishing. I allude not only to London, but provincial papers. Many of the latter are not inferior in any way to their London contemporaries. The cynical impudence of some of them is amazing. Within late years great papers in London and the country have published leading articles condemning systems of quackery exposed in the courts, whilst themselves publishing costly puffs of these same frauds. One paper had a powerful leader pointing out the harm done by sham tonics containing alcohol, and urging that their sale should be prohibited by law. and on the same page printed a costly puff of one of the most advertised of these pernicious preparations. Another great paper published an article which

was, in fact, a brief summary of my address delivered before branches of the British Medical Association two years ago. The article spoke of the quack drug trade as constituting a grave national danger, and, in almost the same words as I had used, exemplified and illustrated the fact by reference to the injurious and deadly results of self-drugging by simple, suffering people. I have made a careful estimate of the income derived by the owners of this paper from advertisements it denounces as fraudulent and cruel, and have satisfied myself that it does not amount to less than £50,000 a year. If a Royal Commission were appointed the owners, these censors of public and private morality could be called as witnesses and asked to justify their conduct. The vendors of nostrums and apparatus would also be called and examined, and confronted with the promises in their advertisements; with the analyses and dissections of their wares, and with exposure of the actual cost of these. There would be unfolded an astonishing tale of cynical villainy on the one hand and of popular credulity on the other. It would force the attention of statesmen to the subject, and means would be found to put an end to the worst of the evils. The Food and Drugs Acts, and the Merchandise Marks Acts serve to check and prevent abuses much less serious; and I have previously shown that amendment of the laws dealing with the offence of obtaining money under false pretences, together with reform of the Medical Acts, would certainly put an end speedily to many of the existing evils. Some philanthropic, patriotic, and public-spirited newspaper proprietors would, under such new laws, probably find themselves in the dock along with the criminals whose profits they are now sharing.

I am, Sir, yours truly, HENRY SEWILL.

March 3rd, 1909.

#### **OBITUARY.**

MR. THOMAS WAKLEY (Editor of *The Lancet*). WE announce with much regret the death of Mr. Thomas Wakley, which took place on Friday last at 16 Hyde Park Gate, London, S.W., at the age of 57. Mr. Wakley, who was born in London in 1851, was the only son of the late Thomas H. Wakley, F.R.C.S., and grandson of the late Mr. Thomas Wakley, M.P., Coroner, who was the founder of *The Lancet*. He was educated at Westminster, Trinity College, Cambridge, and St. Thomas's Hospital, and became a Licentiate of the Royal College of Physicians in 1883. He married Gladys Muriel, eldest daughter of the late Mr. Norman Barron, and has one son, between four and five years of age. He was a Fellow of the Royal Numismatic Society.

Mr. Wakley was best known as Editor of The Lancet, to the joint editorship of which he succeeded in 1887. Socially he was a particularly shy and retiring man, who accepted the responsibility of his position, but in every way avoided public appearance. He was, however, a keen Freemason, and at one time held Grand Office in that Order. His death breaks the editorial succession of a journal the history of which marks one of the brilliant opening stages of medical journalism in the United Kingdom, of which it may truthfully be said that it has become the pattern and exemplar of that and similar literature throughout the civilised world.

The funeral service took place to-day at St. Mary Abbot's, Kensington, and at Putney Vale Cemetery.

PETER HORROCKS, M.B.Lond., F.R.C.P., M.R.C.S. WE regret to announce the death, on February 28th, after an operation, of Dr. Peter Horrocks, Senior Obstetric Physician to Guy's Hospital, at the age of 56. Dr. Horrocks was a Fellow of the Royal College of Physicians and a member of the Royal College of Surgeons. He obtained his M.B. degree of the University of London in 1877, and was awarded a gold medal. He was educated at Guy's Hospital and Owens College, Manchester. At the time of his death

he was Senior Obstetric Physician at Guy's and Lecturer on Obstetrics at the hospital medical school. He was an Examiner in Medicine at the Universities of London, Leeds, and Liverpool, and was also an Examiner on the Conjoint Board of the Royal Colleges of Physicians and Surgeons of London. In 1894 Dr. Horrocks had a narrow escape while Alpine climbing. On returning home he opened a subscription list for the widow and seven children of the guide who lost his life.

DR. JOHN AMBROSE, R.A.M.C.
The sudden death is announced of Dr. John Ambrose, retired Lieut.-Colonel of the Royal Army Medical Corps, who was found dead in his diningroom at Southgate Lodge on Saturday evening. The deceased, who was in his 68th year, had been in his usual state of health. He had dined alone on Saturday evening, and shortly afterwards, when the servant went in to clear the table, she found her master on the floor, partly under the table, dead. The deceased had not been medically attended, but some two years ago he consulted a London specialist in respect of severe headaches. He appeared, however, to be quite cured of these. The deceased officer had been resident at Devizes for a quarter of a century, and was for the greater portion of that time Medical Officer in charge of the station hospital at Devizes Barracks (Wilts Regimental Depôt). He was very popular, and his death is greatly regretted.

#### REVIEWS OF BOOKS.

INTERNATIONAL CLINICS. (a) This is a good clinical number of this popular quarterly journal. In the section devoted to therapeutics, two novelties are discussed. These are the treatment of pertussis by fluoroform, and the treatment of tetanus by cholesterin. Tissier contributes the former paper, and speaks strongly of the value of a watery solution of fluoroform in allaying the symptoms and abbreviating the course of whooping-cough. Further independent testimony is, however, required before one can place undue reliance on his results. The paper on tetanus is written in a modest style by two Italians, Almagia and Mendes. Their treatment is based on their observations on the fixing power exerted by cholesterin and lecithin on tetano-toxin, but their results, as they admit themselves, are suggestive rather than convincing. Sherrens' paper on the diagnosis of injuries of the peripheral nerves from those of the spinal cord is a valuable contribution to the subject, and deserves careful study. Any careful investigator must be aware of the fact that the differential diagnosis of traumatic nerve and cord lesions is often a matter of extreme difficulty, and to such investigators the paper will appeal. Four other papers on nervous and psychical diseases are included in the present volume, the most interesting of them being one by Jastrow entitled "On the Trail of the Sub-conscious." Admirers of Meyers' "Human Personality" will receive this paper with interest, and will find within it some striking records of double consciousness. The section on surgery contains papers on "Melanotic Neoplasms," on "Adenomata of the Thyroid Gland," on "Pericolic Inflammations," and on "The Treatment of Fractures by Direct Internal Splintage." An interesting early case of myositis ossificans is recorded by Dr. Jeliffe, and an account of some cases of leukæmic retinitis is given under the section devoted to ophthalmology by Duvigneaud. The volume, as usual, is well got up, is well illustrated, and is altogether presented in a most attractive style.

INFECTIOUS AND PARASITIC DISEASES. (b)
This manual is intended for the use of medical students and nurses more especially, but at the same

<sup>(</sup>a) "International Clinics." Vol. III. Eighteenth Series. Philadeiphia and London: J. B. Lippincott Co. 1908.

(b) "Introduction to Infectious and Parasitic Diseases." By Millard Langdeld, A.B., M.B., Professor of Bacteriology and Clinical Medicine, John Creighton Medical College, Omaha. London: Rebman, Ltd. 1908. Price 5s. 6d. net.

time it is hoped that medical men will profit by its perusal. We have read it from cover to cover, and feel bound to admit that there is no better introduction to the study of bacteria and bacterial infections. The elementary style in which the book is written makes its study extremely easy to the uninitiated, provided they possess a rudimentary knowledge of medicine. Passing from a consideration of the causes of disease, the author takes his reader in rapid succession through the main principles of bacteriology, the phenomena of infection, animal parasites, and the portals of entry and exit of the various infectious agents and parasites. There is also a chapter on disinfection and disinfectants. The mode of collecting and examining secretions and excretions is likewise briefly referred to.

We notice that the author is of opinion that "very few vaginal discharges in children" are due to any are due to any tion. This is a other cause save gonorrhoeal infection. matter of opinion, with which we are unable to agree. There are surely many other causes, equally frequent, such as measles, threadworms, and the like. The volume has a commendatory note by Professor Barker, of Baltimore, but it stands in no need of any such recommendation; and we feel convinced that no student or general practitioner will regret studying it, as its perusal will certainly give him an insight into the principles of the origin of such diseases as are referred to, and a first knowledge to which he may the more readily add by wider reading. The volume, moreover, is so well printed and so neatly bound that it becomes a veritable pleasure to read and to handle it.

ESSENTIALS OF DIETETICS. (a)

THE object with which this work was compiled was the instruction of nurses in practical dietetics, and assuredly this is a highly important, nay, indispensable branch of their training. Incidentally, of course, it will be appreciated by women who, without any technical training, have to nurse at home, that is to say, the general public.

We can cordially recommend the book, which is admirably written in plain English, and contains just such information, theoretical and practical, as is required by the readers for whose benefit it was written. We are told how to distinguish good food from bad, the various ways of preparing it, and the conditions in which it may be given, together with the abnormal states in which it is to be withheld. There are close on a hundred pages of miscellaneous information and recipes for invalid dishes, with directions for their preparation. For all practical purposes it will be found a useful work of reference even by medical men with whom, as a rule, practical dietetics is not a strong point.

#### Medical News in Brief.

#### The Annual Meeting of the National Hospital for Consumption, Ireland

THE annual meeting of this hospital was held on March 3rd. Her Excellency the Countess of Aberdeen was present. The Chairman, Mr. O'Brien Furlong, C.B., in moving the adoption of the report, said that there were 480 patients treated in the year-22 more than in the previous year; 380 had been discharged, and 10 had died. The average stay of patients in the hospital was 12 weeks. The great bulk of those admitted—268 being men and 212 women—were between the ages of 16 and 40 years; but the highest percentage in the age period was between 21 and 25 years in all groups. Patients were classified in four groups, according to the stage of the disease, and this showed in a striking way the importance of early treatment. The first group contains the patients with early and limited disease—that was, in the incipient stage of consumption; out of 177 cases, 163 were "improved," and of these 57, or 32 per cent., were

(a) "Essentials of Dietotics in Health and Disease." By Amy Elizabeth Pope and Mary L. Carpenter. London: G. P. Patmans'

"very much improved "-that was to say. the disease was apparently arrested and health restored. figures were, he thought, sufficient justification for the existence of that hospital. Where the disease was of long standing, out of 84 cases 31 "improved," and none "very much." That went to show that as a curative agency the sanatorium availed little to restore health,

unless the disease was arrested in its early stages.

Amongst the subsequent speakers were Lady Aberdeen, the President of the Royal College of Physicians, and Sir M. J. Thompson.

Annual Report of the City of Lenden Cere In his annual return to the Home Office, Dr. F. J. Waldo, Coroner for the City of London and Southwark, states that in the year ended December 31st last he held 418 inquests, including non-fatal fire inquests. It was to be noted that 37 fatal accidents were due to vehicles, of which 9 in the City and 13 in Southwark were drawn by horses, and 12 in the City and 3 in Southwark were motor drawn. There was an increase of cases of "suicide," and a decrease of cases of "children suffocated whilst in bed with their parents or others." Of 9 deaths attributable to "neglect, exposure, or excess," only 5 (2 males and 3 females) were found by the jury to be directly due to disease caused by excessive drinking. The Coroner points out that a tentative measure in the shape of a proposed general Appethetics Bill is now under the consideration. general Anæsthetics Bill is now under the consideration of the Privy Council and Home Office, which Bill limits the administration of anæsthetics to registered medical practitioners, and requires that all candidates, before presenting themselves for their final medical examination, shall have received thorough theoretical and practical instruction in anæsthetics, under the supervision and to the complete satisfaction of their respective teachers. He adds that present available data as to deaths during anæsthesia are so imperfect as to be useless for the purpose of formal investigation, and that it is highly desirable to arrive at satisfactory conclusions regarding all deaths under anæsthesia, both for the safety of the public and for the furtherance of scientific knowledge.

The Prujential Assurance Company.

The annual report for the year ending December, 1908, of this well-known Society has reached us in due course. Needless to say, it registers once more that steady increase of prosperity which is synonymous with the name of this well-managed corporation. The directors draw special attention to the fact of a substantial increase in the industrial branch bonus. The total number of policies in force at the end of the year reached the astounding figure of 17,963,127.
There is no more interesting chapter in the history of insurance in the United Kingdom than that which records the rise and progress of the Prudential Assurance Company.

Women Sanitary Inspectors in the City of London.

A MEETING of the Corporation was held recently in the Guildhall, the Lord Mayor presiding. On a report by the Sanitary Committee increasing the salaries of the women sanitary inspectors to £200 each and regulating the appointment of a fresh woman inspector, Sir Robert Rogers said that women inspectors in the City were an abomination and a nuisance. There was no official duty done by a woman which could not be better done by a man. Mr. Link said that the work of the women inspectors had greatly increased in volume and importance of late years, and other authorities outside the City were paying even higher salaries than were suggested. Mr. H. P. Monckton said that the women inspectors worked in some 20 different useful directions; their salaries were about 25 per cent. less than those of men discharging similar duties. The report was eventually carried.

Trinity College, Dublia.

THE following candidates passed the Final Examination in Medicine, Part I., Hilary Term, 1909:—John H. Woodroffe, Marius A. Diemont, and Hilgard Müller (passed on high marks); Arnold K. Henry, Arthur C. Hallowes, Beatrice M. Hamilton, Charles H. Denham and Richard H. Mathews (æq.), Perceval G. Leeman, John W. Flood, John B. Burgess.

#### NOTICES TO CORRESPONDENTS, &c.

Correspondents requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

BUBSCRIPTIONS.

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#### ADVERTICEMENTS.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion, 6d. per line beyond.

FACTORY SURGEON (Hford).—Should a person decline operation through fear of taking chloroform or other annesthetic, the responsibility rests upon himself. The question has been raised in workmen's compensation cases whether the refusal of operation, where the latter is essential to the cure of some defect arising out of the causative accident, should not invalidate the claim for permanent compensation. A recent case in Manchester appears to show that the claimant would under such circumstances place himself out of court. In that particular instance the claimant agreed to be operated upon after hearing the judge's views.

indge's views.

K. G. H. (Cricklewood),—The person you mention is an unqualified person with a West-End establishment. He professes to cure various diseases by massage and physical exercises. Under the circumstances, we should advise your patient to consult a solicitor as to the best course to pursue

SANITARY INSPECTOR.—The next meeting of the National Federation of Meat Traders' Association will be held at Blackpool. Their policy is to place the responsibility of warranty upon the vendors of stock. Their solution seems sound enough. In any case, the natter should be settled, for the safety of the public is closely associated with its speedy solution.

#### Meetings of the Societies, Tectures, &c.

Medical Officers of School. Association (11 Chandos Street, W.).—3.30 p.m.: Discussion on Ought School Boys to be allowed to Compete in Flat and Cross Country Races of more than One Mile in Length? (opened by Dr. W. Collier).

UNITED SERVICES MEDICAL SOCIETY (Royal Army Medical College, Millbank, S.W.).—8.30 p.m.: Major Beveridge, R.A.M.C.: Demonyfration on Some Recent Methods of Sewage Analysis. Mr. B. Harman: Diaphragm Test for Vision.

Royal College of Surgeons of England (Lincoln's Inn Fields, W.C.).—5 p.m.: Prof. A. Keith: Malformations of the Heart. (Hunterlan Lecture )

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. M Collier: Clinique (Surgical), 5.15 p.m. Lecture: Mr. R. H. J. Swan: Vesical Tuberculosis.

North-East London Post-Graduate College (Prince of Wslee's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

Thursdat, March 117th.

Royal Society of Medicale (Obstetrical and Gynecological Sketios) (20 Hanover Square, W.).—7.45 p.m.: Specimens: Mrs. Stanley Boyd: A Necro-biotic Fibroid. Dr. Rivers Pollock: Stanley Boyd: A Necro-biotic Fibroid. Dr. Rivers Pollock: Dermoid Cysts of the Ovaries. Dr. W. Giffard Nash: (1) Parovarian Cyst with Torsion of the Pedicle; (2) Hemorrhage into Great Omentum due to a Slight Injury in a Patient with Multiple Myomata of the Uterus; (3) Hemorrhage into a Sarcoma of the Ovary causing Symptoms Suggestive of Torsion. Dr. Russell Andrews: (1) Twin Pregnancy in a Fallopian Tube; (2) Carcinoma of Vagina, Renoval of Uterus and whole of Vagina, Dr. A. H. N. Lewers: A Fibroid Tumour spontaneously expelled from the Uterus Seven and a Half Weeks after Delivery. Dr. H. R. Spencer: (1) An Ovarian Fibroid urmour spontaneously expelled from the Uterus Reven and a Half Weeks after Delivery. Dr. H. R. Spencer: (1) An Ovarian Fibroid Incarcerated in the Pelvis, Casarian Section and Ovariatomy at Term: (2) Bilateral Ovarian Fibroids removed during Pregnancy.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIO (22 Chenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical). 5:15 p.m.: Lecture Dr. J. M. H. MacLeod: Bullous

Street, W.C.).—4 p.m.: Sh. (Surgical). SIP p.m.: Lecture Dr. J. M. H. MacLeod: Bundass Eruptions.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynrecological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X.Rays. J. p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture: Dr. G. G. Macdonald: The Mechanism of Infection.

St. John's Hospital for Diseases of the Skin (Leirester Square, W.C.).—6 p.m.: Chesterfield Lecture: Ul-Erythema: I., Centrifugum; II., Telangiectic; III., Ophryogenes.

FRIDAT, MARCH 12TH

FRIDAT, MARCH 127H

ROYAL SOCIETY OF MEDICINE (CLINICAL SECTIOS) (2Q. Hanover Square, W.).—Mr. James Sherren: Cases of Nerve Injury from the Point of View of Treatment. Mr. C. H. Fagge: (1) Two Cases of Post-operativ: Facial Paralysis. Facial Hypoglossal Grafting; (2) Case of Inflammatory Facial Paralysis, Facial-accessory Anastomosis. Mr. A. H. Tubby: Nerve-grafting. Mr. Sargent: Case of Nerve-root Grafting. Mr. McAdam Eccles: Charcot's Disease of the Ankle. Mr. A. Carless: Vicious Circle and Vomiting after Gastroenterostomy cured by Entero-anastomosis. Major C. G. Spencer, R.A.M.C.: Sarcoma treated by Coley's Fluid. Dr. Macnaughton-Jones: Cance.ous Tumour of the Spinal Meninges Invalid field Cord and causing Paraplegia, Secondary to Manmary Carcinoms. Dr. F. H. Hawkins: Lymphadenoma with varying Jaundics. Mr. L. McGavin: Perineal Hernia. Short Meningits.

varying Jaundice. Mr. L. MCHAVIII: FETHICAL MACHAVITE PAPER: 940 p.m.: Dr. A. E. Garrod: Urremia simulating Meningitis.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—9 p.m.: Special Meeting: ROTAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Irm. Fields, W.C.).—5 p.m.: Prof. A. Keith: Malformations of the Heart. (Hunterian Lectures.)

MEDICAL GRADUATES COLLEGE AND POLICLINIC (22 Chemics Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique (Throat).

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. A. Wylie: Laryux,

#### Appointments.

CHAMBERLAIN, DURIE AVERT, L.R.C.P.Lond., M.R.C.S., Medical Officer of Health by the Stratton (Cornwall) Bural District Council.

Council.

GRIPPITH. ALBERT EDWARD. L.R.C.P. and S.Edin., L.F.P.S.Glueg.,
District Medical Officer by the Westbury-on-Severn (Gloucestershire) Board of Guardians.

HAMILTON. GEORGE G., M.B.Edin., F.R.C.S.Eng., Consulting
Surgeon to the Boscombe and West Hants Hospital.

SMITH FRANCIS R., M.R.C.S., L.R.C.P.Lond. L.D.S., Surgeon
to the Victoria Hospital for Children, Chelsea.

#### Vacancies.

Brixton Dispensary, Water Lane, S.W.—Resident Medical Officer. Salary, £150 per annum, with furnished apartments, attendance, coal and gas. Applications to W. Halliday, Secrets, y. West London Hospital, Hammersmith Road, W.—Pathologist, Salary, £200 per annum. Applications to R. J. Gilbert, Secretary-Superintendent.

London County Asylum, Horton, Epsom, Surrey.—Junior Assistant Medical Officer. Salary, £160 a year, with board turnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, London S.W.

York Dispensary.—Resident Medical Officer. Salary £150 a year, with board, lodging, and attendance. Applications to Dr. Swanson. The Pleasaunce, Heworth, York.

Gateshad Dispensary.—Assistant Medical Officer. Salary, £180 per annum, without board or lodging Applications to W. Swinburne, Hon, Sec., Town Hall, Gateshead-on-Tyne.

County Asylum, Mickleover, Derby.—Junior Assistant Medical Officer. Salary £120 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Longford Union.—Medical Officer. Salary, £120 per annum. together with the usual vaccination and registration fees.

glord Union.—Medical Officer. Salary, £120 per annum. together with the usual vaccination and registration fees. Applications to J. F. M'Cann, Clerk of the Union. (See advt.)

#### Births.

GIBSON.—On March 7th, at 46, St. Giles Oxford the wife of Alexander Gibson, M.D. of a son.

HARLSER, -On March 4th, at Tynemouth, the wife of W. Edmund Harlser, M.D.D., D.H.y., of a son.

HICHENS.—On March 2nd, at Northampton, the wife of Peverell S. Hichens, M.D., M.R.C.P. of a son.

OWEN.TATIOR.—On March 7th, at Cherwell House, Nottingham, the wife of Herbert Owen.Taylor, Esq., M.D., of a son.

#### Beaths.

BINNING.—On March 4th, at Hatfield, Herts, the wife of Alexander Binning, M.D., aged 29.

WarLer.—On March 5th, at 16 Hyde Park Gate, London, Thomas Wakley, L.R.C.P.Lond., only son of the late Thomas Henry Wakley, F.R.C.S.Eng., and grandson of the late Thomas Wakley, M.P., aged fifty-seven years.

## Influenza and its Sequelæ.

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(Signed) —, L.R.C.P., L.R.C.S., &c.

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(Signed) ---, L.R.C.P., L.R.C.S.

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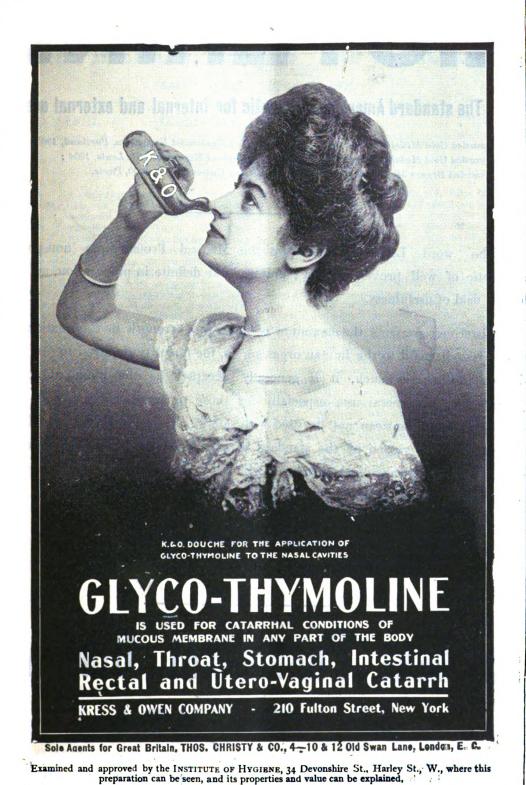
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## THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, MARCH 17, 1909.

No. 11.

### Notes and Comments.

A CORRESPONDENT has drawn atten-Continental tion to a matter that deserves Hotel comment in the interests of our Dectors. travelling countrymen. He refers to the medical men attached to many of the hotels on the Continent, and to the fees charged to visitors who may require their services. In one specific instance quoted by him, a lady of narrow means happened to be stopping in a wellknown hotel in Switzerland, and called in the "hotel doctor" for advice as to a slight sore throat. The attack was controlled by a simple gargle, but several visits were made, and an account sent in eventually at the rate of £2 2s. a visit. The matter is rendered more serious by the statement that the medical man in question was a shareholder in the hotel. The lady might have secured the services of a competent outside practitioner at a fee of ten francs a visit. All who are well acquainted with the Continent know of cases of the kind, and it is a fact that sometimes the favoured medical man is a relative of the proprietor. From our own knowledge we can supplement the experience of our correspondent by that of a young lady who had a slight attack of faintness in a Riviera health resort. The hotel doctor was summoned, and the parents had to pay an exorbitant sum for an absolutely trivial and fleeting ailment.

What is to be Done?

CLEARLY if this sort of thing continues a great deal of harm will be done to Continental hotels. Visitors will fight shy of calling in medical men at all, and much mischief may

result in cases of serious illness. Yet there must be some perfectly simple way out of the wood in dealing with so honourable a profession as that of medicine. Indeed, some hotel proprietors adopt a method whereby any risk of misunderstanding is entirely prevented. Where there is nearly always an official hotel doctor, so to speak, it is clearly understood what are his fees, and at the same time a list of medical men practising in the town is available, and full information as to their fees and other special information is freely given. The travelling public necessarily comes from the monied classes, but the prices of Continental resorts have risen so enormously of recent years that the question of cost becomes more and more a matter for careful consideration. In any case, hotel proprietors will do well to see that the fees charged by medical attendants in ordinary cases are not excessive. Otherwise the feeling of dissatisfaction that has shown itself recently in not a few quarters may, in time, impair the fortunes of more than one wellknown health resort. This is a case in which the Continental hotel proprietor should emphatically be warned in time.

Small-pox at Bristol. For some time past there have been sporadic cases of small-pox at Bristol, introduced, it now appears, by a dock-labourer from the east of

Europe, and owing to faulty diagnosis and the mildness of some of the cases, the disease has become uncomfortably disseminated throughout the city. It is true there have only been twenty-three cases, but latterly they have been occurring in scattered groups at distant spots, and from collateral circumstances it is evident that a large number of persons have been exposed to infection. Dr. Davies, the medical officer of health, who has been doing his best to follow up the cases and to secure re-vaccination of contacts, has found that, owing to delay in notification and other circumstances, he has lost control of the disease, and consequently he fears an outbreak which may be of some severity. The Local Government Board consequently sent down Dr. Sweeting, one of their medical inspectors, who advises that, as a first step, facilities for vaccination and re-vaccination should be offered by the Guardians. His suggestions are that the vaccination officers should visit infected neighbourhoods and offer vaccination, that posters and bills indicating the necessity for the operation should be published, and that re-vaccination should be carried out, if need be, at workshops and factories.

Guardians as lature having conferred on the guardians the power to make arrangements for vaccination, rather than on the sanitary authority, to which

such matters would naturally be referred, it follows that the important duties of carrying out Dr. Sweeting's advice devolves upon them. Last week he attended a special meeting of the Guardians and laid the situation fully before them. Now it seems there is a strong anti-vaccinationist party of the Board, and Dr. Sweeting was not only treated with sneers by some of these gentlemen, but his advice was scouted by them. One person seems to have made himself especially obnoxious, refusing even to obey the chairman, and talked the usual clatter of his class about medical faddism, and so on. Eventually, after an animated debate, the motion to carry out Dr. Sweeting's proposal was defeated by 26 votes to 16. It remains to be seen what course will be taken by the outbreak in the first place, and the Local Government Board in the second. The latter body has power to supersede the guardians if it thinks fit, and no doubt if an epidemic threatens it will not hesitate to do so. The health authorities are doing their best, but if a widespread epidemic takes place, Bristol will only have itself to thank for having elected gentlemen of the present stamp to represent its interests.

THERE have also been two cases of small-pox at Bolton, which are said to have been infected in a rather curious way. The medical officer of health attributes the source of the

disease to the handling, by a female operative, of Egyptian cotton. Formerly there was no small-pox in Bolton, but in Egypt the disease is fairly prevalent. The medical officer of a neighbouring town considers that the method of infection consists in the habit which the women have of licking their fingers to enable them to piece together broken threads, and suggests that a moistened pad should be provided to enable them to do without the licking process. Certain it is that small-pox can be conveyed by fomites, and undoubted examples of infection by this method have occurred over and over ogain, so that it is quite likely that the Egyptian cotton may be the source of infection. On the other hand, it is by no means easy to assert that the disease can be incurred by any particular habit, and it is still more certain that to make factory operatives adopt any plan which they are unaccustomed to and which entails trouble, is a herculean Surely the simplest plan is to have all the hands re-vaccinated.

Milk Depôt Closed. The policy of establishing milk depôts for babies in large towns has always seemed to us a rather doubtful one, because it is in itself an admission that the milk is

dangerous, and consequently that somebody should be prosecuted. We cordially admit that the measure was undertaken from the best possible motives, but it has seemed as though its advocates were working at the end instead of at the begin-Certainly in some boroughs some apprening. ciable success has attended on their efforts, but in others it has not been so apparent. In Finsbury, last month, the Borough Council decided by a substantial majority to close their depôt, which has been but little patronised and has had no appreciable effect on the infantile mortality. therefore, of spending £400 or £500 in that way, they propose to appoint two health visitors at £100 a year. It is earnestly to be hoped that, busy as this session is, Mr. Burns will push forward and carry through his Milk Bill. Important, doubtless, as are the other measures before Parliament, there is hardly a single factor in the health of the nation which needs more drastic handling than the milk question, and as such it should be recognised in the Government programme, and dealt with accordingly.

#### LEADING ARTICLES.

THE CHARITY OF THE PROFESSION.—II.

The money earned by medical men in the practice of their profession is seldom, if ever, enough to enable them, after duly providing for their families, to leave any considerable sum to medical charities or other philanthropic objects. Brewing, soap manufacturing, and the distillation of spirits frequently bring to the presiding geniuses a superfluity of wealth, and such of them as give money to the charities of their neighbourhoods receive the plaudits of their fellows. The charity which a medical man can expect to receive, when laid low by illness, due to devotion to duty or to accidents of his profession, is little enough, and of reward from the

State he gets nil. Truly, to the honour of the late Prime Minister, it must be recorded that he conferred a Civil List pension on Dr. Hall Edwards, whose misfortune and suffering we all deplore. But the amount at the disposal of the First Lord of the Treasury for pensions is ridiculously small, and in the present temper of the community we can hardly imagine that a proposal to appropriate, say, a quarter of a million a year for the benefit of sufferers from the accidents of their work in civil life would be received with other than an outburst of economic indignation. Standing charges are already enormous, and sources of taxation are heavily burdened. Dreadnoughts are luxuries which have to be paid for, and the recent addition of Old Age Pensions-with which, of course, we are all thoroughly in sympathy-will place a heavy burden on the Exchequer for a long time. To look to the Government to do anything for the medical men who fall by the wayside is, therefore, we fear, to look in a direction from which no help is likely to come, even though, as we showed last week, some members are freely giving as much as onefifth of their income to the medical needs of the community. Thanks to the Workmen's Compensation Act, sufferers from industrial accidents and diseases are now provided for at the expense of their employers, but the medical man, being his own employer, in nearly all cases has nothing to gain from the Act- except to pay for injuries to his own servants. But though, as we have said, the practitioner is, in the eye of the law, his own employer, his real employer is the public, to whose service he devotes himself, and it is not unfair to expect it to render to him the same service which he renders to his own employees. That is to say, that it is a just and proper burden on the public exchequer to contribute to his support when, from accident or disease incurred in its service, he is laid aside, temporarily or permanently. The obligation, indeed, is different altogether from any similar one that might pertain to other workers, for, apart altogether from the private practice by which he supports himself, the medical man is continually rendering service to the State by his unpaid work to patients whom he knows never can or will pay, to hospital patients who are not expected to pay, and by performing functions, such as giving death certificates, which protect the weal of the State in one way or another. It is pitiable to think that with nearly every fresh class medical appointment, whether it be that of medical officer of health, or medical inspector of school children, the authorities categorically lay down that no retiring or compassionate allowance is attached to the post, and frequently that the appointment must be regarded as running for one or three years only. Almost more pitiable is it that these posts should be rushed after by numbers of highly qualified and experienced men, who seem to regard three or four hundred a year as the summum bonum of their ambition. With this trend in public opinion it is plain that the profession must rely more and more on itself and on its combined influence and fighting qualities. Salvation comes not from any point of the compass but from within, and loyalty to colleagues and solidarity of aim are the qualities that are needed. An example of what may be done in the way of charity to the profession is given by the late Mr. George Smith, M.R.C.S., L.D.S., of Manchester, whose will was published last week. His estate was sworn at £11,669, and, subject to several bequests, he left the residue in equal shares to the Royal Infirmary, Manchester, and to University College Hospital, London, to be used for the benefit, not of the patients, but of one or more of the surgical or dental staff who may be incapicitated from work by being infected by any puncture, or contracting blood-poisoning from examining or operating on patients, or conducting post-mortem examinations. This is a noble example and worthy of all imitation. Medical men often, after a life devoted to hospital work, leave any money they have to their institutions, but how much more acceptable would it be if bequeathed to those of their successors who are wounded in the battlefield of medicine, and without such help would probably find themselves stranded or dependent on the good-will of friends who can ill afford to support them.

# CURRENT TOPICS.

The Live Burial Bogey.

THE Society for the Prevention of Live Burial pursues its path with unabated vigour, in spite of the sandy soil on which their structure is raised. Time after time they have been asked for scientific evidence of the occurrence of live burial, but no absolute and convincing cases have so far been Of hearsay and presumptive testiforthcoming. mony there is an infinite amount, but on investigation it may be questioned whether any single alleged instance on record would suffice the critical demands of any careful observer. One of the common fallacious stories is the gruesome tale of sounds issuing from a coffin, presumably caused by the efforts of the resuscitated person to attract attention. It has long ago been pointed out by an author who carefully investigated the whole subject that the amount of air in an air-tight coffin would not suffice to keep a human being alive for many minutes. It is equally certain that life could not be maintained for more than a few brief instants without the performance of the respiratory function. From these premises it follows that no human being could recover animation after having been shut up in an ordinary air-tight coffin for more than a few moments. A few days since a grave was being filled up at Leigh, a village in Staffordshire, when rapping sounds were thought to be heard proceeding from the coffin. The undertaker speedily unscrewed the lid and sent for a medical man, who found nothing but a dead body, and no evidence that there had been any movement. The coffin was replaced, and as the grave was being filled up a second time rapping was again supposed to occur. Had the affair not been at once investigated it would doubtless have added another to the bogus stories quoted in support of the gruesome assumption that live burial is of frequent occurrence. The life of man is already surrounded by a sufficiency of trials and difficulties without adding gratuitous terrors to the list. Why should not the possibility of live burial be investigated by a responsible committee, say, one appointed by the Royal Society?

Registration of Nurses.

THE path of those who seek for the State registration of nurses has not been made easy. In the first place, the medical profession has always regarded the proposal of registration of nurses with some suspicion, as leading to the possible establishment and recognition of a rival order of practitioners. It will be remembered, too, that last year, when a Bill for the purpose was introduced in the House of Lords, and at the instance of the Government, Ireland was omitted from its operation, a tremendous outcry arose in that country. It was pointed out, quite correctly, that if there was to be State registration of nurses, the system should apply to the entire Kingdom. Finally, the Government had to give way. Now, however, a new difficulty has appeared. The nursing profession of Scotland, backed by the medical profession, is demanding exclusion from any English Bill, and is calling for Home Rule in this matter. In some points the scheme put forward by the Scottish nurses has advantages over the Bill which passed the House of Lords last session, but we hardly think the advantages sufficient to counterbalance the inconveniences of having different systems at work in different parts of the Kingdom.

Landlords and Insanitary Tenants.

So much has been heard of the evils of landlordism, especially in poor neighbourhoods, that an attack on their tenants comes with an attractive air of novelty. The bad landlord and the bad tenant together furnish a picture of slum desolation the description of which is familiar in the articles of the descriptive newspaper reporter. But the good landlord and the bad tenant is a combination that does not lend itself so readily to effective journalistic treatment. The point was raised recently at a meeting of the Midland Sanitary Inspectors' Association at Birmingham by Dr. Robertson, Medical Officer of Health for that city, who boldly asserted that the time had come for demanding powers to deal with dirty and destructive tenants. He was persuaded that a great amount of harm was caused to landlords by tenants who caused dilapidations, not only to their own houses, but to those of their neighbours. He deprecated any desire to whitewash landlords or agents, but he could not help feeling that there were a great many cases in which reasonably clean and decent houses were provided, but which were brought into a dilapidated and insanitary condition by the tenants. The opinion of this speaker was that the law should be altered in the direction of giving the landlord greater power than at present for getting rid of undesirable tenants. At present the landlord undoubtedly experiences great difficulty in getting sufficient evidence to support the application of an ejectment order. The law has, in point of fact, carefully regulated the relations between landlord and tenant, and on the whole its administration works with reasonable success. Hard cases are bound to occur at times even under the best-considered human institutions. We doubt if the existence of a certain number of dirty

destructive tenants would warrant any change in the existing law. Landlords must be prepared to take the good with the bad tenants in slum properties, just as they have to do with honest and dishonest tenants in middle and upper-class society. Reduced to its simplest terms, the monetary damage comes to much the same thing whether due to the loss of rent or to the damage to house property. The chairman of the inspectors' conference summed the matter up when he said that there were tenants who broke up the stairs and doors for firewood, and landlords who would not put on a coat of paint. There was much to be said on both sides, and betwixt them the sanitary inspector had his work cut out. At the same time, there had been a great improvement in the slum property of Birmingham. That happy result, happily more or less universal in the United Kingdom, is probably in no small measure due to the efficiency and sound technical education of the sanitary inspectors as the administrative officers of an enlightened system of local sanitation.

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# Sanitation in Irish Schools.

We have more than once commented on the shockingly insanitary conditions which are characteristic of many of the primary schools in Ireland. In Belfast particularly the school inspectors have repeatedly drawn attention to overcrowding, bad ventilation, neglect of cleansing, and absence of closets. From a recent report we learn that, allowing the modest space of ten square feet to each pupil, the accommodation is insufficient in 27.7 per cent. of the Belfast schools. In only 48.3 per cent, is it ample. In one school where there is accommodation for 40 pupils the inspector found 112 present; in another where there was accommodation for 12, 36 present; and in a third, 80 children crowded into a space sufficient for 18. He gives the figures of several other schools where two or three times the proper number of pupils were present. The conditions throughout the rest of the country, though not quite so scandalous, give cause for grave dissatisfaction. It is impossible to calculate the injury done to the future of the country by bringing up the children in such surroundings. It is not merely the noxious effect on their own health that we consider, though we regard the health of a child as of much more importance than the learning he acquires at a primary school. In recent years lessons in hygiene have been introduced into the school curriculum. Can anything be more ridiculous and hypocritical than to give instruction in hygiene to children crammed by force into such filthy dens as the schools of Belfast? The force of example goes far, and it is no wonder that the slums of Irish towns show such a high deathrate when these are the conditions which Irish children are brought up to regard as normal or proper. We say without hesitation, that children would be better without any schooling than with the schooling they get under such circumstances.

# Medical Education in China.

An appeal to the nation is being made by the China Emergency Appeal Committee on behalf of the spread of Western education in China. It is supported by a number of distinguished philan-

thropists, under the presidency of that great Chinese authority, Sir Robert Hart. The catholicity of the movement may be gathered from the fact that its supporters include, amongst many others, the Lord Mayor of London, Lord Alverstone, Lord Strathcona, Sir Albert Spicer, Messrs. A. T. Buxton, Robert Barclay, George Cadbury, Samuel Morley, J. S. Fry, the Archbishop of Canterbury, T. H. Warren, Vice-Chancellor of Oxford University, Sir William Turner, Vice-Chancellor of Edinburgh University, Sir Donald Macalister, Vice-Chancellor of Glasgow University, Principal Fairbairn, the Rev. T. Scott Lidgett, the Rev. Ian Maclaren, and Mr. C. T. Studd. The general idea is to spread Western education by the training of Chinese students and the development of a central university. As regards medical colleges, it is proposed to place on a thoroughly sound footing four of the existing medical schools that have been established in connection with the mission hospitals. Quite recently a medical school has been founded at Peking, which has been recognised by the Government and whose students are privileged to obtain a diploma to practice from the Imperial Board of Education. Needless to say, the present methods of Chinese native medical practitioners are barbarous and cruel in the extreme. In fact, trained medical men are unknown outside the missionary hospitals, save in the case of the navy and of a portion of the army. £40,000 is asked in aid of medical training colleges. While the Appeal Committee intend to carry on their work in a spirit of Christianity, it is important to note that their work is one of education and not of evangelisation. An important public meeting was held yesterday at the Mansion House, London, when the whole scheme was fairly launched.

# A Poor-Law Tragedy.

FROM time to time we are sharply reminded that bumbledom, with its red-tape officialism, is still in our midst. The Midwives Act (Special) Committee have advised the London County Council that the several boards of guardians within the county should be required to pay the fees of medical mencalled in by midwives, and that the Local Government Board be asked to take action in a similar direction. The Committee quote the following tragedy: -A midwife was called at 8.30 p.m. to a case in the Hackney Union. Seeing that the patient, a young woman, was very ill, she went for a doctor, and returned with him at 10.15 p.m. He advised the obtaining of an order from the relieving officer for the attendance of the parish doctor. Then the business of the circumlocution office began. The nurse called upon the parish doctor in whose district the patient's friends believed they lived. He said the patient's house was not in his district, and referred the nurse to the relieving officer of another district. This officer, when called upon, said the house was not in his district, and in his turn referred the nurse to a third relieving officer. being now very late, she went to officer No. 3 at 9 a.m. next morning, and found that he had left for his office. She then went to the parish doctor for the district and asked him to see the patient. He said the father of the patient must obtain an order from the relieving officer, and he would visit. the case at eleven o'clock. The nurse returned to the patient's house, sent the father to the relieving officer, and herself gave all her attention to the patient. The patient died at 12.15 p.m., two minutes before the parish doctor arrived. details are eloquent in their condemnation of a system which, in these days of telephones and instantaneous communication, makes such a tragedy possible.

The Measles Epidemic.

FROM all parts of the Kingdom news has come of wholesale epidemics of measles. Schools have teen shut, many deaths have been recorded, and local health and education boards have been awakened to the gravity of the situation. In many instances public notices have been issued warning parents as to the methods of infection and instructing them in the recognition and the special risks of the disease. As the period of incubation varies from nine to sixteen days, during the whole of which time-especially the two or three days before the appearance of the rash—the patient is infectious, it seems hopeless to attempt to isolate sufferers with any chance of success. The way to stamp out measles is probably by an absolute system of notification, isolation, and quarantining of exposed persons. At present any counsel of the kind is one of perfection, standing upon an unapproachable On the other hand, as every medical practitioner knows, measles is a comparatively harmless malady when properly nursed, a fact that renders the special education of parents upon the point invaluable. The early recognition of the disease and the keeping of the patient warm in bed would almost, if not altogether, prevent the greater propagation of complications such as bronchitis, pneumonia and middle car troubles. Another way in which local authorities may do much to check the spread of measles is by urging upon citizens the necessity of the thorough disinfection of a patient's environment. The publication of detailed statistics of the mortality due to measles, as compared with scarlatina, enteric fever and other infectious diseases, usually regarded as far more deadly in their nature, would also help in impressing upon the mind of the man in the street the necessity of treating measles with due respect.

# PERSONAL.

THE PRINCE AND PRINCESS OF WALES, on March 10th, paid a visit to the Royal College of Surgeons of London. Their Royal Highnesses were accompanied by Sir Frederick Treves, and were received at the College by the President, Mr. Henry Morris, the Conservator, Professor Arthur Keith, and the Secretary, Mr. S. F. Cowell.

During the afternoon of March 12th, the Prince of DURING the atternoon of March 12th, the Prince of Wales drove to University College Hospital, Gower Street, and made a tour around the different departments and wards. His Royal Highness, attended by the Hon. Derek Keppel, was received by Sir Thomas Batlow, Bart., M.D., K.C.V.O., the resident medical officer the mattern and the acting secretary; who conofficer, the matron, and the acting secretary; who conducted him round the hospital. The Prince also went through the new buildings of the medical school, and the nurses' institute.

THE DUKE OF MARLBOROUGH, the President, took the Chair at the annual Court of Governors of the Royal National Orthopædic Hospital, held on March 4th in the hall of the new Out-Patient Department.

THE LORD MAYOR presided at the annual meeting of Governors of the Royal Hospital for Diseases of the Chest, City Road, at the hospital on Monday last.

MR. JAMES CANTLIE, F.R.C.S., has been appointed a Knight of Grace of the Order of St. John of Jerusalem.

PROFESSOR KIPPING has been awarded the Lougstaff Medal of the London Chemical Society for 1909. This medal is given triennially for excellence in research

DR. WALTER RAMSDEN, M.A., M.D., Fellow and Junior Bursar of Pembroke College, has been chosen Senior Proctor for the ensuing year in the University

MR. CHRISTOPHER ADDISON has been appointed Examiner in Anatomy to the University of London, and Chairman of the Board of Intermediate Studies of the same University.

THE National League for Physical Education and Improvement has organised a series of five lectures to be given on Thursdays at 3.30 p.m. at 35 Holland Park Avenue.

FROM the funds placed at the disposal of the London School of Tropical Medicine by Sir John Craggs, grants have been made to Dr. B. M. Wilson, of Fiji, and Dr. R. Howard, of the Universities' Mission to Central Africa.

THE annual conversatione of the West London Post-graduate College, Hammersmith Road, London, W., will be held on Wednesday, March 24th, at 8.30 p.m. All past and present members of the College are cordially invited.

On Friday next Captain C. F. Craig, of the United States Army, will read a paper before the Society of Tropical Medicine and Hygiene, at the Medical Society's Rooms, at 8.30 p.m. His subject will be, "Observations of the United States Army Board for the Study of Tropical Diseases in the Phillipine Islands,3

At the annual meeting, on March oth, of the Liverpool Maternity Hospital and Ladies' Charity, Sir William Hartley offered to erect and equip a new hospital at a cost of £15,000. The conditions were that the committee should find a site, and that an endowment fund of £20,000, limited to fifteen years, should be raised. Sir William was thanked for his generous offer, and a contribution of £1,000 towards the endowment fund was promised by Mr. Sutton

Dr. Nicolas Weliaminoff, Privy Councillor of State and Professor of Surgery at the Imperial Military Academy of Medicine, St. Petersburg, having been unanimously elected an Honorary Fellow of the Royal College of Surgeons, was presented to the Council on March 11th, and signed the roll. The distinguished Russian surgeon, who is at present on a visit to this country in attendance on the Empress Marie Feodorovna, was nominated for election in 1900, when the Honoray Fellowship was instituted, but was unable to come to England at that time.

At the same meeting the President reported that Sir Gilbert Blane medals, conferred every two years on two medical officers of the Royal Navy, "for skill on two medical omcers of the Royal Navy, "for skill and learning in the exercise of their professional duties," had been awarded to Staff-Surgeons Charles Rowley Nicholson, of His Majesty's ship Egmont. and Arthur William Bligh Livesay, M.B., His Majesty's ship Bonaventure.

# A CLINICAL LECTURE

ON

# HEMIPLEGIA DUE TO SYPHILITIC ARTERITIS.

By Prof. G. MILIAN, M.D.,

Physician to the Paris Hospitals.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

HEMIPLEGIA of syphilitic origin is in most instances due to arterial lesions, and in such case the attack presents certain distinctive features consequent upon the mode of production of obliterative endarteritis, which is the underlying cause thereof. This does not obstruct the lumen of the vessel all at once, but in a steadily progressive manner, so that the softening that ultimately follows does not take place immediately. There is a preliminary period of uncertain duration during which we meet with functional disturbances, with what Potain used to call meiopragia, while all the while the process of arterial obliteration is going insidiously on. Then by-and-bye the obstruction becomes complete with consequent cerebral ischæmia. This is the meiopragic stage, of variable duration, which gives cerebral arteritis of syphilitic origin its peculiar characteristic physiognomy.

I have just mentoned that the symptoms of cerebral arteritis do not set in all at once; they supervene one or two at a time, in succession, the progress being more or less rapid according to circumstances. The course of the disease may be roughly divided into three periods: (a) A period of functional disturbance corresponding to invasion of the vessel, during which the patient complains of painful or other manifestations, these, however, not having any direct bearing on the terminal symptoms; (b) a meiopragic or paretic stage corresponding to partial obliteration of the vessel, during which we get in an attenuated, incomplete, intermittent form the terminal symptoms; and, lastly (c) the paralytic stage, corresponding to total obliteration of the vessel and consequent softening of the brain.

First Period.—The first symptom to appear is headache, a premonitory symptom which, by its severity, often places it in our power to avert irremediable mischief by constraining the patient to apply to his medical adviser for relief. This headache presents much the same character as the syphilitic headache—viz., it is fixed, severe, is worse at night or in the evening, and is refractory to analgesic medication. This is common to all syphilitic affections of the encephalon. It may exist a long time—six, eight or ten months, for instance, before any signs of hemiplegia make their appearance. Fournier mentions the case of a woman who suffered from violent headache for upwards of four years, incessantly, and the headache already very intense during the first three years, became excruciating during the fifteen or eighteen months that preceded the onset of the paralysis.

There may also be sundry subjective symptoms affecting the special organs of sense: dazzling of the sight, blurred sight and sparks in the visual field, with noises in the ears, humming, &c.

The patient may, in addition, be conscious of some impairment of memory with diminished aptitude for work, associated with mental depression, prostration and drowsiness. These premonitory symptoms are rarely wanting.

Second Period.—At this stage of obliterative arteritis the symptoms begin to get more pronounced and are directly dependent on the ischæmic troubles of the cerebral regions involved. The most frequently observed symptoms—those that constitute the common form of cerebral syphilis, are hemiplegic manifestations, accompanied or not, as the case may be, by aphasia, according as it is the right or left side that is attacked.

The immediately-preceding meiopragic phenomena may be either sensory or motor. The sensory disturbances, the existence of which need not surprise us, seeing that the sensory area of the cerebral cortex is in juxtaposition to the motor area, consists in numbness of the limb with a feeling of cold and tingling in the extremity, but these manifestations are, as a rule, more or less fugitive. In some cases the sense of touch is blumted, the patient feels as if he had a glove on, while, in others, there is hyperæsthesia of the region that is to become hemiplegic.

Fournier relates the case of a patient who, three weeks before an attack of left hemiplegia, complained of marked hyperæsthesia over the anterior surface of the left thigh, while the posterior surface of the limb, on the contrary, was anæsthetic. This observer insists on what he calls the "cerebral pains in the limbs," a grave symptom, in that it is the precursor of hemiplegia.

Personally, I must confess that I have not observed anything of the kind, and I cannot admit that it be possible to prognosticate hemiplegia on the strength thereof, since the pains do not present any particular characteristic feature which would enable us to differentiate them from the pain of any deeply-seated local syphilitic accident that is not accessible to palpation. They are merely vague local pains occurring in a limited region of the body, in a limb or the extremity of a limb, going and coming, appearing and disappearing, and they are usually described as rheumatoid, neuralgic, osteocopic, &c. They tend to recur constantly in the same region, and then one day this region becomes hemiplegic.

The motor phenomena are more characteristic of threatening paralysis. We get tremors, limited to a limb, sometimes associated with muscular twitchings. The commonest symptom is fugitive weakness of this or that part or limb: arm, hand, lower limb, &c. The hand gets clumsy, the grasp is lax and writing becomes difficult. A patient of mine complained to me that when out walking she was continually letting her umbrella drop, in fact, that she could not grasp it with her right hand. The very next day she was seized with brachial monoplegia on that side, soon followed by complete hemiplegia with aphasia.

One of Fournier's patients had several fugitive attacks of lingual paresis lasting a few minutes; later on he had numbness of the left arm. One day, when out shooting, he noticed all at once that he was unable to hold his gun in the left hand. This scared him, and he made off home and went to bed and to sleep, and when he awoke things were all

right again, but a few months later he was stricken with hemiplegia.

Sometimes it is the lower limb that is seized with sudden weakness and gives way, causing the patient

to stagger or fall down.

In the same category of symptoms must be placed fugitive attacks of aphasia, for no one nowadays discusses the existence of a special syphilitic form of aphasia. Aphasia is due to changes in a given region of the brain and not to any particular morbid lesion. The attack of aphasia may be followed in a few hours, days, or months, when transitory, by right hemiplegia. In this case it is motor, and not sensory, aphasia. But we must beware of errors of diagnosis. Fugitive aphasia is but rarely the prelude of hemiplegia due to cerebral arteritis. On the contrary, it very frequently ushers in general paralysis, but, to put it more clearly, it is often the flagrant symptom that reveals to us the existence of latent general paralysis. As a matter of fact, in general paralysis it is anarthria rather than aphasia, of defective articulation rather than loss of word-memory. It is accompanied by lightheadedness and restlessness, indicative of irritation of the cortex consequent upon meningo-encephalitis.

Aphasia is to syphilitic arteritis what the shadow is to the body, and follows its evolution step by step. In conjunction with the hemiplegia, it forms a very distinct entity with a symptomatology peculiarly its own, and without any collateral manifestations, such as convulsive attacks, excitement. delirium, &c. Take, for instance, the case of a young man, æt. 23, who had contracted syphilis six years previously and had not undergone any treatment worthy of the name. At a ball, while dancing a quadrille, he was seized with a most extraordinary weakness and found himself unable to articulate a single word, in fact, he would have fallen to the ground had his partner not held him on his feet. He was conveyed home without having been able to articulate anything beyond a few disconnected monosyllables. He was put to bed and went to sleep, but on awakening the following morning he was completely aphasic, with right hemiplegia.

Paralytic Period.—Here we are confronted with fully developed hemiplegia; this, at any rate, is the commonest terminal symptom, and it obtains in at least 50 per cent. of cases of cerebral syphilis.

The hemiplegia affects three distinct forms: General, i.e., complete from the onset; general, but

progressive; successive, or by stages.

General and complete from the onset is the form of constituted hemiplegia ne varietur. From the earliest moment the paralysis attacks half the body, face, body, upper and lower limbs—that is to say, it is general. Then, too, it is complete, no movement of any kind being possible. This form is somewhat rare.

The general, but progressive, form also affects the entire half of the body, leaving no segment untouched (general), but the paralysis may not be absolute. Certain movements may still be performed in the affected areas, so that, in fact, it enly amounts to paresis. Not until later—a few hours or a day or two—does the paralysis become complete. This form is more frequent than the preceding, but, nevertheless, it is not the usual form.

Successive and by stages, this is the normal, usual form that is met with in association with obliterative arteritis. The paralysis first shows itself in a limb or segment of a limb—the hand, for instance. On the following day it extends to the face, and later on to the lower limb, until the hemiplegia is

complete. In short, it is hemiplegia by a succession of monoplegias.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Hor ce Law, M.D., Throat Surgeon to the Adelaide Hospital, Dublin. Subject: "Tertisty Syphilis in Upper Air Passages."

# ORIGINAL PAPERS.

THE DIAGNOSIS AND TREATMENT OF CHRONIC ULCER OF THE STOMACH AND DUODENUM. (a)

By ALEXIS THOMSON, M.D., F.R.C.S. Edin.,

Surgeon, Royal Infirmary, Edinburgh.

THE paper was based on a consecutive series of 50 cases in which a chronic ulcer was demonstrated at the operation. Of the 50 cases, 22 were duodenal and 28 gastric ulcers, the sites being as follows:-Pyloric ring, 16 (32 per cent.); lesser curvature, 12 (24 per cent.); first part of duodenum, 17 (34 per cent.); multiple ulcers, one being duodenal, 5 (10 per cent.). He estimated the proportion of ulcers met with on the so-called anterior wall of the stomach as 95 per cent. of all cases. Thirty of the patients were males, and twenty females; the gastric ulcers were equally divided between the two sexes; males preponderated among the sufferers from duodenal ulcer in the proportion of eighteen to four. In the gastric ulcer patients the average age onset of symptoms was 32, of the duodenal ulcer patients 38 years. A noteworthy feature in the histories of nearly all cases was the occurrence of long periods of remission from all symptoms. In three patients there was no pain at all, and in another three the pain was trifling. Constant pain was not likely to occur in cases of ulcer of the lesser curvature. As a general rule, the pain of lesser curvature ulcers was situated to the left of the middle line, of pyloric ring ulcers in the middle line, and of duodenal ulcers to the right of the middle line, but there were many exceptions. Often he had asked a patient, just before beginning to operate, where the painwas, and had been assured that it was under the left costal margin, yet, on opening the abdomen, a duodenal ulcer had been found. In most cases pain was aggravated by taking food, and it was generally supposed that the reason for this was that the ulcer was irritated by the acid gastric juice. He doubted this explanation on the following grounds: -Pain was rarely a prominent feature in acute gastric ulcer. The pain occurring in disease of other hollow viscera is due to muscular contraction. He believed that the pain of gastric and duodenal ulcer was due to peristalsis caused by food, not to the irritation caused by the acid gastric juice. Pain came on from a half to one hour after food in cases of ulcer of the lesser curvature, from one to two hours in ulcer of the pyloric portion, and about three hours after food in duodenal ulcer. In most cases of duodenal ulcer the pain was quite uninfluenced by the nature of the diet. Sometimes pain was re-lieved by taking food, as in the case of "hunger pain," in which, when the stomach was empty, the patient suffered from epigastric discomfort and pain, at once relieved for the time being by eating. In explanation of this symptom, which occurred in cases of duodenal ulcer, it had been supposed that

<sup>(</sup>a) Paper read at the Edinburgh Medico-Chirurgical Society, March 3rd, 1909.

the pain was due to the acid contents of the stomach flowing over the ulcer; when food was swallowed the pylorus closed and put a stop to this. He thought, however, that it was quite possible that it was simply due to the empty stomach pulling on the pylorus and tending to draw it to the left. The relation of the pain to the attitude of the patient was inconstant; there was no evidence to show that relief to the pain by lying either on the face, or on the back, was of any localising value— the majority of the ulcers met with were on the Tenderness was anterior wall of the stomach. chiefly due to the existence of adhesions. Vomiting was present in 42 cases (84 per cent.); the cases in which it was missed were chiefly duodenal ulcer. In 29 cases (58 per cent.) there was hæmatemesis; in 11 there was also melæna. The great majority of cases showed an excess of free HCl; in four cases of ulcer of the lesser curvature free HCl was absent. Butyric and lactic acids were of little importance in the diagnosis of ulcer or its seat.

Treatment.—In most cases chronic gastric ulcer was incurable without operation. Of the two operations, resection and gastro-enterostomy, the latter was preferable. Resection should be restricted as far as possible; it was an extremely difficult operation as compared with resection of cancer, and the mortality was high. On the other hand, with modern methods, gastro-enterostomy should not have a mortality of much more than I per cent. He had to report the following results of fifty operations:-Resections, 3. One operation death; 1 perfectly well 3\frac{1}{4} years later; 1 2\frac{1}{3} years later, has still some pain and flatuience. Gastro-enterostomies, 47. Three operation deaths in the first 15 of the series, making a mortality of 6.4 per cent.; of those who survived I has been lost sight of, and 5 have died at various periods from other than stomach causes. Of the 38 survivors 1 is slightly anæmic, 1 has some distension, 2 a little flatulence and occasional bilious attacks; the rest unanimously record marked increase in weight and complete freedom from stomach symptoms, 25 of these being reported on from 1 to 71 years after operation, the remainder within the year.

# SOME CASES OF HYDATID DISEASE OF THE LIVER. (a)

BY G. P. NEWBOLT, F.R.C.S.ENG.,

Examiner in Clinical Surgery, University of Liverpool; Surgeon, Royal Southern Hospital.

DURING the last few years ten cases of this disease have come under my observation, and as they are not so very common in this country, some observations upon them may be of interest. Nine out of the ten patients came from North Wales, and in the majority of these a history of living on a sheep farm and of contact with dogs was obtained. The one exception had never been out of Liverpool. Four were in males, and six formula in formu and six in females. The youngest was 8 years old, and the oldest 54. Jaundice was present in three cases on admission, and has been transient in others; operation was carried out in each instance, one patient dying. In one instance the cyst was reached through the chest wall, in the others by means of an abdominal incision. The operations were performed in one stage, the hydatid removed where possible, and the edges of the capsule brought to the abdominal wall with strong silk, large drainage tubes being inserted. On two occasions two cysts were discovered.

Diagnosis.—Usually the diagnosis was easily made, but in Case to it presented difficulties; in fact, even after the abdomen was opened, matters were not quite clear at first. The patient, a male, æt. 31, had been

ill for eight months prior to admission; he had been jaundiced for three months, and complained of a good deal of pain in his liver, which was considerably enlarged, both lobes being affected. The pain was accompanied by attacks of vomiting and sweating, whilst under observation his pulse was 94 and his temperature 100°. On examination the left lobe of his liver was of stony hardness, considerably enlarged downwards, and very tender. The right lobe was enlarged upwards and downwards, and also felt very hard; there was no sense of fluctuation, and no thrill. The jaundice, though considerable, was not complete, and the stools were not clay-coloured, though the urine contained bile. There was no history of syphilis, nor did any improvement take place under iodide and mercury. As the pain became so much worse and the temperature kept up, it was thought wiser to explore. On the day before exploration he had one of his acute attacks of pain, and could only lie curled up on his right side. The attack simulated gall-stone colic. On March 4th, 1908, I opened his abdomen in the middle line, exposing the liver, which was partially shut off by adhesions; there were some hard nodules on the surface of the organ, and it looked very much as if the man was suffering from malignant disease. However, on puncturing one of these projections, a small amount of pus escaped, but nothing further, and this did not account for the symptoms. I next explored the left lobe with a needle passed from the middle line, and evacuated a large hydatid cyst with clear contents; but the temperature, pain, and sweating pointed to the presence of something more than this, so I pushed a needle deeply in at the point where pus had first escaped, and after going some 3 in. struck a suppurating hydatid cyst. This I opened with dressing forceps, introducing a large rubber tube, through which a number of daughter cysts and portions of cyst wall escaped; hæmorrhage was free, but the tube and a plug of gauze restrained it. The man was put back to bed, and soon after collapsed rather badly, but continuous saline injections per rectum restored him, and next day he was better. The left cyst soon became obliterated, but the cavity on the right continued to discharge large amounts of bile and cysts for several weeks. In order to demonstrate the size of the cavity a rubber tube filled with mercury was passed and the patient Xrayed; the tube was found to occupy the greater part of the posterior portion of the right lobe of the liver. The question of diagnosis was the most interesting The amount of pain was far greater than in any of the other suppurating cases I have seen; in fact, it resembled the pain of a perforating viscus. Even after opening the abdomen there was no sense of fluctuation. In tapping the cysts the needle was arrested by a dense fibrous wall, necessitating considerable force to make it penetrate. Evidently a slight leak had occurred, leading to the superficial collection of pus and the localised peritonitis shutting off the peritoneal cavity in the median line. The possibility of the disease being malignant or gummatous was kept in mind when exploring. From the amount of bile which escaped immediately after operation, a large duct was either involved by the cyst or opened at the duct was either involved by the cyst or opened at the time of operation. The following case bears also on the question of diagnosis. Mary W., æt. 9, was sent up from the country with a tumour of the right side in the hepatic region, supposed to be a hydatid. After examination I had very little doubt that I had to deal with a hydatid cyst involving the right lobe of the liver. The tumour gave a distinct sense of fluctuation; it was painless, and apparently incorporated with the liver, but there was no thrill; it projected backwards into the right loin, and the liver dulness did not extend upwards. A nodule the size of a hazel nut could be felt in the abdomen below the umbilicus. The ward examination of the urine gave it as normal. On exploration the tumour proved to be a small roundcelled sarcoma of the right kidney growing forward and lying in contact with the right lobe of the liver. It was soft and vascular, so much so that after removal of a piece for examination I had to plug the wound with gauze for two days before closing it up. The

<sup>(</sup>a) Read before the Liverpool Medico Chirurgical Society, July, 1908.

nodule in the abdomen proved to be a gland, and segregation of the urine showed that a few blood-cells were present. No attempt was made at removal, as the abdominal glands were involved, and the child died six weeks later. The vena cava was pressed upon, and there was a secondary growth in the brain.

The cysts, however, do not always point forwards,

but may present towards the chest, and we then have a different state of things. This is well shown in Case 2. Alice P., a girl, æt. 12, was transferred to my care for the purpose of exploratory operation on August 7th, 1900. She had been ill for some months, suffering from shortness of breath and discomfort in the right side. Her abdomen was swollen in the upper part, and retracted below. The margin of the liver was visible during respiration. The liver dulness in the mammary line extended from the upper border of the third rib to 21 in. below the costal margin. The margin of the lung expanded about an inch on inspiration over the dull area. Breath sounds were weak over the dull area in the axilla, elsewhere fairly well marked. Vocal resonance and fremitus were conducted. Respirations were 32, the pulse 90, and the temperature varied, often being 101°. On palpating the liver there was distinct but regular enlargement of this organ below the ribs, but nothing like a cyst could be made out. The conclusion arrived at was that there was a hydatid in the liver pushing the lung upwards, and an exploring needle drew off pus. On August 7th, 1900, under chloroform, I aspirated through the eighth inter-space in the mid-axillary line, and got clear yellow fluid which had a very foul smell. I again put the needle through the ninth interspace, with a similar result. I therefore removed a piece of the ninth rib, and opened the chest. The lung, which was healthy, at once retracted, and the wall of a cyst bulged up at the lower part of the wound. More rib was resected in order to get a free exposure of the parts, and the cyst was again aspirated. Having drawn off some 8 oz. of fluid of the same character as before, I caught the now flaccid wall of the cyst and drew it up into the wound, stitching it around to the soft parts so as to shut off the cavity of the chest. On opening the cyst freely a large quantity of fluid escaped, with numbers of cysts of all sizes, some of them containing pus. I was able to get away the whole of the endocyst in one piece, and drained the cavity left with two big tubes packed around with gauze. The girl stood the operation well, but her temperature ran up to 1020, her pulso became 120, and her respirations 64. For several days she gave rise to much anxiety, but eventually made a good recovery, leaving hospital in November. doubt the pus obtained when exploring was due to one of the smaller cysts being punctured. The opening of the chest and interference with the diaphragm probably gave rise to the quick respirations and general upset after the operation, and I have seen the same condition of affairs after opening a liver abscess in the same way. In the majority of my cases the hydatids were painless until they suppurated or until they pressed upon important structures. Many of the patients had jaundice at some time or other, and several complained of pain in the right shoulder and of losing flesh. Percussion of the convex upper edge of the liver and an X-ray view of the shadow thrown by the liver, in most instances enable us to diagnose between a cyst and a pleuritic effusion. In addition we may have the descent of the margin of the lung over the cyst, varying percussion note.

Treatment.—In dealing with the cysts that have come under my care I have adopted one method only, and that is to expose the cyst by an incision made, whenever possible, over the most prominent part of the tumour, to open the cyst, empty it and drain it. The majority of the cysts were operated upon through the abdominal wall, i.e., nine out of the ten. If after exposing the cyst it is found to be adherent, so much the better; if not, it must be packed off from the surrounding parts with gauze. The cyst is then aspirated and the fluid contents drawn off. Anyone who has observed the force with which the fluid is ejected from a tense hydatid cyst must realise the danger of

exploring one of these tumours without having first exposed its wall and shut it off from the abdominal cavity; the fluid often escapes not only through but by the side of the needle used. Again, in Case 6, the hydatids apparently were dead, for the cyst had been noticed to be getting smaller, and on aspirating nothing escaped; yet a free incision revealed a cyst full of hydatids, without any free fluid—here the preliminary exploration with a needle would have been very misleading. When the greater part of the fluid has escaped, the cyst, if superficial, can be drawn up into the wound, freely opened and emptied. All the daughter cysts are removed, and as a rule the endocyst comes away; the edges of the cyst are then fixed to the margin of the abdominal incision by strong silk sutures cut long so that they can be used as retractors when dressing the wound. The gauze packing is removed from the abdomen as the cyst is stitched up. The cavity is packed with gauze, and later on kept open with a large rubber tube. The healing process is slow if the cyst is large, but it is safe and usually unattended by complications. A large cyst takes about three months to close up soundly, but the patient is generally able to get about some four or five weeks after operation. When the cyst is deeply situated in the liver the method is slightly different. Having exposed the liver, shut it off from the abdomen, and located the cyst with a needle, a long pair of dressing forceps is pushed along the exploring needle. Having established a track, a half-inch drainage tube can be passed by means of dressing forceps; this will drain the cyst perfectly well, and if necessary larger tubes can be inserted a few days later. The gauze packing which was used to shut off the abdomen is left for two days and then removed. Daughter cysts will continue to escape for some days, and the temperature will show if there is any retention.

I usually irrigate the cavity after the first dressing. In one of my cases in which the cyst was situated low down near the anterior margin of the liver, I was able to pull it up into the wound and remove about half of its anterior surface, but I have never adopted the operation of enucleation, the mortality of which is given at 17 per cent. If the cyst is small, the cavity will soon close whichever method is adopted; and, if large, the obliteration of the cavity by means of sutures must be both difficult and dangerous. secondary drainage has had to be performed in some of the cases so treated, the safe and sure method of drainage from the first is surely to be advised. one should be careful when operating to avoid soiling the edges of the wound with the contents of the cyst is well shown by Case 5, in which when a large cyst was opened several of the daughter cysts escaped in the wound. The abdomen was shut off, but the wound was an extensive one, and, although carefully washed out, implantation must have occurred, for a year later the patient returned to me with a cyst about the size of a pigeon's egg situated at the lower end of the scar. This was excised, and there was no further trouble. It is well, therefore, to protect the edges of the wound with gauze whilst operating. In those instances in which the wall of the cyst has become calcareous, the convalescence is likely to be a very tedious process, but they seem to heal. In one of my cases the posterior surface of the cyst was covered with calcareous plates. I tried to move one of these, but failed to do so. The recovery was very slow, but the cyst had existed for a long time before operation was performed. In cases in which the hydatid presents towards the chest wall it should be opened in this situation. If low down, the cyst may be reached below the reflection of the pleura. In the one instance I have experience of, the healthy chest was opened and the cyst wall, formed of pleura, diaphragm, and cyst, was fixed in the wound after removal of a portion of the ninth rib. It was then drained. I have recently seen a second case in which the same condition is present, but here I shall go lower down and avoid opening the pleura if possible. No doubt in some of these cases the two layers of pleura are adherent from pressure of the cyst, and all that is needed is a simple incision, with, possibly, removal of a portion of rib to give free drainage.

In conclusion, I have to thank my colleagues, Dr. William Williams, Dr. Macalister, and Dr. Lloyd Roberts, from whose wards the majority of the cases have been transferred, and to whom I am indebted for their valuable opinions.

# STATE CURE OF LEPROSY IN NORWAY AS IT AFFECTS OTHER COUNTRIES. (a)

BY ALBERT S. ASHMEAD, M.D.

[SPECIALLY CONTRIBUTED TO THE MEDICAL PRESS AND BY THE AUTHOR.] CIRCULAR

I HAVE spent a good deal of money on the private investigation of immigration of Scandinavian leprosy, and therefore can speak advisedly on some matters concerning it. I have devoted a great many years of my life to the special study of the disease in many lands, and know the views of a number of men who are eminent as leprologists. As one of the provisional committee of the Berlin Leper Conference—Hansen, of Norway, and Goldschmidt, of Funchal, Madeira, being the other members—I was prominent, in the contest between the strong contagionists and those who opposed their plea for a declaration favouring obligatory isola-

tion of all lepers.

The men of Russia and of France stood, with Goldschmidt and myself, in our demand that that conference should be held at Moscow, in a country where the leprologists are strong advocates against facultative isolation. The leprologists of Great Britain, a non-contagion country, wanted the conference to be held in London. But as they demanded that the Prince of Wales (now King Edward VII.), a strong anticontagionist, should be president of the congress, we would not agree and stood loyally to Russia. Hansen. would not agree, and stood loyally to Russia. Hansen, a member of our committee, then withdrew from it, when he found that we were about to issue our call for the meeting at Moscow, and joined in with the other Scandinavian countries, especially Denmark with Germany, and precipitately called the conference for Berlin. He was most interested in obtaining from the conference a declaration for facultative isolation of ispers, as practised in the Mixed Law of Norway. He appeared the London men by accepting Virchow as President of the conference, Virchow being a non-contagionist. When the conference was called to order, through Oscar Lassar of Berlin, I introduced a resolution for international unity of action regarding all matters concerning lepers, and especially intended to restrict the Inspector-General of Norway, Armauer Hansen, from shipping, or allowing to be shipped, lepers and leper families from his country to the United States, as had been going on for many years. Of course, Hansen led an attack against the proposal. I was defeated, and his original plan of conquering leprosy in his country by his faulty facultative law has been allowed to complete itself. In my investigation of Scandinavian leprosy in the United States, I found that surely (perhaps more) 316 full-flown lepers, known to the authorities of Norway to be lepers, had been allowed to emigrate to this country, and 175,000 leper families, in each of whom one or more lepers had been found, had been shipped as emigrants to America.

Many, if not most, of these families surely carried the latent germs, or perhaps suspicious, or as yet undeclared cases of the disease. Besides, the operation of the same law, in Iceland, put in effect through Ehler's efforts (a great admirer of Hansen and everything pertaining to him) has deluged Canada's North-West Provinces, as Dr. Smith, of Tracodie informs me, with many lepers. Our own North-West, Middle States, the Dakotas, and some other States, have also received through Winnipeg, a facultative centre of leprosy, a number of Ehler's Icelandic lepers. Facultative isolation is responsible for all this emigration evil of leprosy to the United States. Of greatest im-

portance, then, to this country, directly connected with the transference of these latent germs by the successful operation (for Norway) of Hansen's Mixed Law of isolation and its adoption by other countries, is the question-whether the disease is contagious? One-half of the population of Norway has been permitted to come here, while Hansen was being glorified for the gradual eradication of leprosy from his country. And now, in his honour, a second conference on leprosy has been called to meet at Bergen next August. It is, therefore, of supreme moment to learn whether this transference of 900,000 Scandinavians has not been the main factor by which Hansen has almost com-pletely conquered the Norwegian evil. Norway is a country with only 2,000,000 population. There are left behind there only 500 lepers to be cured by the operation of Hansen's facultative law of isolation. Perhaps when he has shipped here the remainder of his leprous families, there will be no lepers found in Norway. Two of the three lepers asylums in Norway have been long closed, as there was found to be no further need of them as Harsen's law was successfully operating "In closed, as there was found to be no further need of them, as Hansen's law was successfully operating "In 1920," he says, "there will be no more lepers in my country." "If you seek my monument, look about you." By that time all his lepers will be dead, and the suspicious ones translated to the United States.

We therefore must study two questions pertaining to leprosy with deepest diligence—contagion of the disease, and its epidemiology. Let me state here what is known and believed in by men of science who have treated leprosy, and nothing else. It is our "confession of faith," and those who subscribe to it will enter the leprological heaven. But those benighted heathen scientists, like the dermatological counsellors of our Roard of Health, who have condoned the non-isolation of lepers in New York, and who have refused the benefits of obligatory segregation, are condemned to the bottomless pit of utter leprological darkness. Most leprologists who have seen service in countries where leprosy has become epidemic believe in the following

Leprological Creed :-

LEPROLOGICAL CREED.

We believe First: That leprosy's invasion of a virgin country, as is shown by its history from immemorial past, in every situation, is divided into three stages: first, one of sporadicity, when only imported cases are found, scattered and appearing singly from time to time, with longer or shorter intervals, and without any connection the one with the other. period lasts in every country from 50 to 100 years.

Second: That there comes now a stage of endemicity, quietly and insidiously, unexplainable, when cases are discovered, first slowly appearing in succession, and then more rapidly, among those inhabitants who have never been away from the country. This stage lasts from 100 to 150 years. It sometimes takes on an appearance of regression, when only those leprologists who really know the habits of the disease are not deceived by it. For instance, at Abbeville, Louisiana, a very old endemic centre of leprosy, Dr. Edwards, a member of the State Board of Control, writes me, under date of November 2nd, 1908, as follows:—"There appears to be a certain amount of periodicity attaching to the outbreaks which have occurred in this parish in the last fifty years, the disease appearing with uniform regularity about every ten years, and each time the outbreak occurs there has been a period of several years during which time not a case of the disease is known to have existed in the parish. It is now about time for another outbreak. and I am more or less on the qui vive in consequence.

A like peculiarity is now being noted in Minnesota, where for a long veriod only sporadic cases imported from Scandinavian countries were found. Now, as from Scandinavian countries were found. Now, as Dr. Bracken recently wrote me, there exist three cases of endemic lepers. The so-called Mixed Law of isolation, as practised and so grandly lauded by Dr. Armauer Hansen for his own country, has so singularly failed when practised in both these situations on American soil

American soil.

Third: After the endemic period comes the horrible stage of epidemicity, with all its serious effects for State Government, and people, strangely and always suddenly, without insidious or stealthy approach.

<sup>(</sup>a) Paper read by invitation in the New York Academy of Medicine (Section of Medicine), as a Contribution to the International Discussion on January 19th, 1909.

Hundreds and thousands of victims are found and multiple in families. The types are severer with many mutilating cases. Evidently the virulence of the disease has slowly acquired strength through the endemic period. Contagion, too, would seem to have acquired a voracity for victims through multiplication of the foci, or perhaps by some insect order, or more than one of suctorial pests, has become gradually infected with the germs, and now act as intermediary hosts for the propagation of the disease, by transmitting the spores or bacilli. We conclude, therefore, from the histories of the disease in every climate, and every race, since knowledge of leprosy was acquired, wherever the disease has passed through these three stages, sporadic as it exists now, in New York and our Eastern States, endemic as it already exists in Minnesota, and endemoepidemic as it already presents itself in our negrowhite State, Louisiana:—

First: That the disease respects neither sex, age, nor social condition, and most naturally affects those individuals of any race who are of delicate organisation, or debilitated by wretchedness, privations, excesses, or previous disease.

Sciond: That leprosy spreads itself in all latitudes, and that New York can be no exception to the contagion, no matter what the eminent advisers of our Roard of Health foolishly claim to the contrary, and no matter how prominent and distinguished those dermatologists are in their own speciality, they are not epidemiologists. Leprosy is a science in itself.

We believe also that the disease follows man in all zones, from the frozen regions of Siberia, Greenland, Iccland, and Norway, to the parched districts of India and equatorial Africa. Hence it could not be that those formulated theories which have been specialised in any one place could absolutely be of the same nature everywhere. For instance, that of Jonathan Hutchinson and others about the consumption of fish (as alimentation, not as intermediary host) will not admit of analysis as a sole factor in contagion, in the presence of statistics of this plague in peoples who have never eaten fish, or very sparingly; and in the presence of the further fact that in some places where fish and nothing else was eaten there was never leprosy known until an imported human body had brought the germs. These facts are also really proofs for contagion which Hutchinson strangely persists in refusing to believe in.

Hutchinson strangely persists in refusing to believe in. The one thing which conduces most to the prevalent error about leprosy is that the duration of the latent period is totally undetermined. When and how comes infection? Does anyone know? And who knows whether, before the disease can verify itself, the patient must experience some particular alteration of health? Then only symptoms of invasion known to us as leprosy can present themselves. Who of those stricken can ever know whether, and when and how, in some country infected by leprosy, he has stayed in contact with a leper, has lived in a house once or now occupied by a leper, or touched some things belonging to a leper?

Only continued microscopical examination, made daily of the individual while in such a country, could precisely declare the moment of the invasion of the bacillus of Hansen. Thus it is easily seen how impracticable it is; and, besides, it would be just as difficult as to determine the exact starting-points of the disease throughout the world; to keep in memory all the incidents of one's life that may have taken place everywhere, and of long duration, to keep in view the fixation of the absolute manner and conclusion therefrom as to the predisposing cause of the disease—all this would be little short of impossible unless one devoted his whole life to the work of finding out whether he was becoming a leper or not.

We believe that the disease is naturally infectious—that is, transmissible as malarial fever, yellow fever, cholera, typhoid fever, are, either by direct or indirect methods of contact. We cannot explain its spread anywhere, independent of either hereditary influences, family contagion, contagion fer se, or by some other such circumstances, intermediary host function, or intermediary transmission direct, as determining cause. The theory of heredity (not family contagion) has been rejected by the scientific leprological world. All the

proofs that were ever adduced to support it have actually failed before complete conscientions and scrupulous analysis. Only in Latin America and in some pagar, lands is heredity still believed in.

To-day intra-uterine contagion is accepted. And

there is much reason, without perfect proof, for its truth. It is difficult for anyone to understand, without forgetting the physical law of its impenetrability, the bacillary infection of leprosy as it may unfold itself in the fecundated masculine germ, or feminine ovule. In either case the phenomenon could not verify itself without profoundly altering the organisation of the germ or ovule, in which case there would be no fecundation, and, in consequence, no heredity of leprosy. Or, if there was fecundation, there would he a diseased product of conception, which as yet we have never seen carried to full term in spite of Zambaco's claim to have seen nine cases born leprous. These cases of his are thought by leprologists really to have been syphilitics. Zambaco's refusal to accept belief in non-heredity is considered by leprologists as unsound. It is a fact that children have become leprous soon after birth when created by leprous fathers. But in all such cases it is believed that the intercourse of the father with the mother, after she had conceived, has infected the fœtus through the amniotic fluid; or, where the child was born, when the disease had already appeared in the mother, that it was due to the presence of bacilli in the maternal leprous breast, just as may happen in gonorrhoal infection of the amniotic liquid. I myself saw a child, born totally blind (intra-uterine gonorrheal conjunctivitis), whose father I had treated for gonorrheea when the mother was 51 months pregnant. Intrauterine gonorrheal infection destroyed the sight of this That a leprous seminal fluid, or an infected germinal egg, would produce a viable child, is not believed. Intra-uterine contagion is all that is believed in by leprologists.

It is believed also that the danger of the contagiosity of leprosy increases in direct ratio with the unfolding of the disease—that is to say, that it is more difficult, or less probable, to contract leprosy from a patient who is in the first period of his disease, than from another farther advanced. The mediate, or immediate contact with a leper, is not in itself sufficient to produce the disease in a healthy individual, as follows in all other affections which are eminently contagious.

Heedful, constant and perspicuous observation demonstrates without giving place to the least doubt that for contagion of leprosy to verify itself it is necessary that there co-exist as much for the healthy one as for the diseased one—a real series of conditions on both sides, which may be defined thus: Conditions of transmissibility in the diseased, and conditions of receptivity in the healthy, and which require as indispensable factors not alone some individual circumstances, but those of time, of place, and of manner.

The contagion of leprosy is greater or less, in accordance with the form by which the disease reveals itself, and the period of its unfolding. The mutilating form, for example, is most virulently contagious, when the fingers and toes are eliminating themselves, are about to drop off, or some other parts of the body, show openings, which suppurate and ulcerate, and are terminating their processes of separation. Contagious transmission of leprosy has been attributed by many leprologists to some insects, especially flies and fleas, which may propagate the leprous virus directly on their feet and beaks. To-day there are a number of us who firmly believe that mosquitoes also are vehicles of transmission. I believe that not one insect, but many different species, act as real intermediary hosts, perhaps permit the virus, while they are carrying it, to acquire some peculiarly contagious quality. Carrasquilla affirms to have encountered the bacillus of Hansen in the stomach or intestines of fleas, and infers that some other insects may likewise transmit the disease. I am inclined to believe further than this, that in reality it may be transmitted by the different insects of a country, in different potentialities, if they bite the diseased persons at the different stages of the disease's development or progress, and

afterwards apply their infected organs of suction to the tissues of well persons, which would be equivalent to a real, direct inoculation of the poison. Hallopeau and Montegazza both confirm this belief. The first says :- "It is very probable that the intermediary hosts, and particularly mosquitoes, may habitually serve as propagators of the disease." "We are in accord," says the other, "with those who have given us the evidence of this method of infection." Zambaco Pacha continues obstinately to deny contagion of leprosy. And Virchow, even to the hour of his death, fought against belief in it, as he had previously done at the conference of Berlin in 1897. He declared that "contagiosity of leprosy could not be established as a dogma, until we have found cultivable and inoculable the bacillus of Hansen." In spite of these eminent objections, there prevails to-day, in the science of leprology, a firm belief in contagion of leprosy, both immediate and intermediate. Besnier has graphically defined it in these few words:—"Leprosy comes from lepers, and by no other way, and where there are no lepers there can be no leprosy."

A WORD ON STATE-CURE OF LEPROSY. There are but three methods of State-cure known to science to free a country of epidemic leprosy

(1) Destruction of all lepers by death, or their outcasting absolutely from families. India and Japan have tried this, but because of its imperfect applica-tion it has failed in both countries. The lepers did not die fast enough.

(2) Obligatory segregation (mis-named isolation)—that is, the taking of all lepers away from their families. This has been done successfuly in smaller communities, but is not practised perfectly anywhere

in larger countries.
(3) Deportation of all lepers as fast as they develop

(3) Deportation of an iepers as fast as they develop in families. No State can conquer epidemic or even endemic leprosy except by control of family contagion. Hansen knows this very well. Facultative isolation of lepers only keeps alive family contagion. It really multiplies it. So that only by deportation of his families infected by leprosy, has he so nearly accomplished a State cure for his country. If we should plished a State cure for his country. If we should apply the Mixed Law of Hansen, in this country, as will very likely be advised at the Bergen Conference, we must not only have passed by Congress, a law like that proposed by Senator Perkins, of California, which would deport the lepers from our States to Molokai, but we should also deport those families which prefer to keep their lepers at home. Facultative isolation per se as a State remedy is a farce, unless we adopt also deportation. Obligatory segregation of all lepers is the only safe rule without the practice of wholesale deportation of the infected families.

The present situation of matters here, is as follows: -The number of lepers in the United States, of all nationalities, is far in excess of the number 278, reported by the Marine Hospital Congressional Investigation Committee, of which Dr. White was chairman, under an Act of Congress in 1898. I estimate the whole number to be really about 3,000. Of this number, 400 are Scandinavians, according to Dr. Bracken's estimate. The N.O. Picayune estimated the number of Louisiana's lepers to be 400, of whom only 50 at most are hospitalised near White Castle. It has been estimated that there must be at least 300 Chinese lepers in the United States. This estimate comes to me from Fukien and Quantung Provinces, China. Most of them are employed in washing the linen of Americans, that is, are hidden in laundries. the records of 164 lepers who have been in New York. When the Marine Hospital reported 7 as the number here, I knew of 16. Icelandic lepers are frequent in our North-West States. And Cuban lepers, "mostly rich persons," according to Dr. Robelin, of Havana, freely come and go among us here in New York. In a Colombian boarding-house, down town, I could show you three lepers.

There have been introduced into Congress four leper Bills which have been killed in Committee. Congress having failed utterly, therefore, to help out the situa-tion, as a last resort, I have lately made an appeal, through the Evening Post, of New York, for funds to establish a philanthropic National Leper Asylum. And I have suggested that the Adirondacks be selected

as its site. As our New York Board of Health claims that leprosy is not contagious in this climate, there can be no logical objection made by our people to its establishment there. Or if there is legislative interference, let us put it on some national territory, some place away from the coast. This whole matter might assume a more wholesome aspect, if we could provide assume a more wholesome aspect, it we could provide for its government by a private National Board of Leper Control, fashioned, in a manner, on that of Louisiana, with the objectional features eliminated. A philanthropist might, in fact, appoint his own Board of Leper Control, a member for each State. Or, each State Board of Health could appoint each a member, who collectively would be the "National and the could be the "Varional and the could be the co member, who collectively would be the "National Board of Leper Control of the National Leprosy Asylum." Nothing can be done, however, until we Asymm. Nothing can be done, however, until we find a philanthropist noble enough to take hold of this enterprise. In the course of time (or eternity, perhaps) we may find a way to carry it forward. In the meantime we still will hope that some good may yet come out of our worldly Nazareth.

# OUT-PATIENT'S ROOM.

GUY'S HOSPITAL.

Hernia: Complications after Reduction. By R. P. ROWLANDS, M.S., F.R.C.S.

AMONG the out-patients was a middle-aged man who had had a left inguinal hernia for many years. In the early hours of this morning, Mr. Rowlands said, the patient woke up in pain and found that his supture was lown, and he could not replace it. A doctor was called in, who reduced it without much difficulty, but the patient states he felt a good deal of pain soon afterwards, and that the swelling in the scrotum returned three or four hours later. At present he is cold and blue, and his pulse is quickened (110), and his breathing thoracic and catchy. The temperature is subnormal. He is suffering a great deal of pain in the abdomen, especially in its left side and lower part. He states that the bowels were opened at 8 this morning; he has been sick once since then. The abdomen is distended, and it only moves a little in the upper half; it is very tender in the left iliac fossa, and the irredi cible swelling occupies the left side of the scrotum. This is dull on percussion, except at the upper part, where it is resonant; there is shifting dulness in the flanks; the rectum is empty, and reveals nothing abnormal. With regard to diagnosis, Mr. Rowlands remarked, it is a little uncertain. The main possibilities are:-(1) Return of the hernia, which might have been incompletely reduced; (2) reduction en masse, the band having been reduced through a laceration in the neck of the sac; (3) volvulus of the reduced intestine. The sac reached down to the testicle, so that it could not have been displaced upwards, and therefore the only two kinds of reduction en masse that seemed probable were—(1) by laceration just below the neck of the sac, and (2) displacement into a sac which had gradually formed in the retro-peritoneal tissue as a result of the constant resistance of a truss at the external ring over the inguinal canal. Although the rapid development of very grave symptoms seemed to point to one of these so-called reductions en masse, there were many points against this view. The abdomen was unusually distended for a reduction en masse of such a short duration, and there was an uncommon amount of tenderness and rigidity of the lower half of the abdomen. Moreover, there was no mass to be felt, and no dulness could be made out, both of which are almost invariably to be found in cases of reduction en masse if they are carefully looked for. For the same reasons the return or recurrence of strangulation seemed insufficient to explain these grave symptoms. Moreover, the greater part of the sac was dull on percussion, whereas it should be resonant. The diagnosis of volvulus was supported by the great amount of abdominal distension and the rigidity of the abdomen supervening within a few hours of the first symptom. The fact that the bowels had been opened once was of no consequence, because it only indicated the emptying of the lower bowel below the obstruction. In any case, Mr. Rowlands considered, an immediate exploration was strongly indicated.

The man was at once admitted into the hospital, and Mr. Rowlands explored the hernia. The greater and lower part of the sac contained only blood-stained fluid, but a loop of gangrenous bowel projected into the upper part of the inguinal canal. The lower fibres of the internal oblique and transversalis were divided to give a better view, and, after some difficulty, many coils of gangrenous small intestine were brought down from the left iliac region, and the cause of the obstruc-tion was then revealed. The great omentum had become adherent to the posterior wall of the neck of the sac, forming a strong, thick, irregular band, round which the reduced intestine had become flexed and strangulated. The small intestine had descended on the right and in front of the band, and had been reduced on the left side and behind it. The bowel was greatly distended and black; the constriction was so tight that it had torn the mesentery and ruptured some of the mesenteric vessels; there was a great deal of blood and sanious fluid in the lower part of the abdomen; this no doubt accounted for the dulness in the flanks and for the early signs of peritoneal irri-

Five feet of intestine were resected, and an end-toend anastomosis by direct suture was made. The sac was removed, and the wound sewn up in layers except for a small drain. Directly after the patient returned to the ward a subcutaneous infusion of a pint and a half of saline was given, and ernutin (min. x.) was injected bypodermically every four hours. Nothing was given by the mouth for twelve hours, and then only small sips of water.

The patient was progressing favourable three days after the operation.

# OPERATING THEATRES.

ROYAL FREE HOSPITAL.

FIBRO-CYSTIC DISEASE OF THE TESTICLE.-MR. JOSEPH CUNNING operated on a man, æt. 34, who came to the hospital complaining of a scrotal swelling. enlargement had been noticed for only five weeks, was not painful, but caused a feeling of heaviness, which had called the patient's attention to the swelling. There was no histor, of injury, of syphilis, nor of any previous illness. Mr. Cunning pointed out that the correct way to examine a scrotal swelling was to grasp the neck of the scrotum between the thumb and the index finger: by this means purely scrotal swellings could be differentiated from swellings projecting from the inguinal canal into the scrotum. At the same time any thickening in the vas deferens or other structures of the cord would be discovered. In the present case it was at once demonstrated that the swelling was purely scrotal, and there was no thickening of the vas. The swelling itself was either a tense fluid or a very elastic soft, solid one. On testing it with a light it was discovered to be completely opaque, so that if the contents were fluid it must be a hæmatocele. Hamatoceles, he said, occurred under two different sets of circumstances: the first being a very definite injury, but even then only in a patient, as a rule, who had a long-standing hydrocele; and the second being when a malignant new growth of the testis was present. As there was no history of injury or hydrocele in this case, Mr. Cunning thought that it was of the utmost importance that the scrotal contents should be investi-There was no resemblance to gummatous disease of the testis in this case, for, given the tumour was a soft solid one, it was everywhere of the same consistence, whereas in a tumour which is the result of tentiary syphilitic condition it should be possible to feel the healthy epididymis apart from a round, softer swelling occupying the testis. If the tumour were the result of tuberculous disease it would be possible to demonstrate indurated nodules in the epididymis, possibly soft caseating areas, and probably thickening of the cord as well.

At the operation an incision was made just below the external ring, the scrotal contents being squeezed

up and made to project through the incision. The object of making the incision in this region instead of in the scrotum itself, Mr. Cunning pointed out was that the firm skin could be rendered more certainly surgically clean than the loose scrotal integument, and also that union is much more rapid. On opening the coloured fluid flowed out, but, on enlarging the opening, the cavity was found to be occupied by a large uniform swelling of the testis, with the epididymis thinned and flattened out lying upon it. The tunica albuginea was everywhere smooth, glistening and healthy, and it was impossible to tell by examination whether the consistence was the test of a feather the consistence was the feather the consistence. whether the consistence was that of a soft solid or of fluid, but Mr. Cunning said he must confess he knew of no such fluid tumours which caused a uniform enlargement of the testis, and he felt so strongly that this was a soft, solid growth that he had no hesitation on deciding upon its removal. The testicle, epididymis and cord were then stripped up to the external ring, the vessels of the cord were ligatured separately and the tumour removed. The wound was closed and the tumour removed. The wound was closed without drainage after all bleeding points had been carefully searched for and ligatured; particular attention, he considered, ought to be paid to this point, for a hæmatoma was very apt to occur owing to the loose nature of the scrotum and the difficulty of keeping adequate pressure upon it afterwards.

Mr. Cunning then proceeded to examine the tumour by splitting it. It was then seen that the conditions were as follows:—There was a tumour evidently beginning in the rete testis and expanding the secreting structure of the testis, so that it was spread out as a thin sheet over the growth. The growth itself was a solid fibrous-looking structure with cysts in it, containing clear fluid, and varying in size from that of a pea to that of a bean. In the largest of the cysts seen there were intra-cystic projections. It was clear, then, that the tumour was of that rare kind known as fibrocystic disease of the testis, the pathology of which is still very obscure: it is clearly not of a malignant nature, but if left will certainly cause ulceration in the skin over it, so that the only treatment possible is

excision of the testicle.

The subsequent progress of the case was satisfactory.

# TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

MEETING HELD FRIDAY, MARCH 12TH, 1909.

The President, Sir THOMAS BARLOW, Bart., K.C.V.O., in the Chair.

Mr. James Sherren showed a series of cases illustrating nerve injury from the point of view of treatment.

CASE I .- MUSCULO-SPIRAL PARALYSIS OF UNUSUAL ORIGIN. Male, æt. 26, fractured his left clavicle playing football two and a-half years ago. The arm was put up in Sayre's position with bandages which were removed on one occasion during the month of application, and at this date there was no paralysis. Seven weeks after this he had an operation for mal-union of the clavicle; he said that the nerve was not touched. He had not improved, and did not seem to have had any systematic treatment since he left hospital.

He had come under observation at the London Hospital on March 4th, 1909. All the muscles in the forearm supplied by the musculo-spiral nerve were paralysed, the supinator longus, extensors of the carpus, and fingers and thumb. The triceps was acting nor-There was altered sensibility over the radial area of the hand, but no loss to any form of stimula-The muscles did not react to stimulation with the interrupted current, but reacted well to the constant. With a smaller current than on the sound side they contracted fairly briskly, and there was no polar reversal. The actual cause of injury was uncertain.

The only suggestion put forward was that it was the result of the bandaging, although the exhibitor had never seen the nerve injured in this way before.

CASE 2.—ILLUSTRATING AN UNUSUAL CAUSE OF MUSCULO-

SPIRAL PARALYSIS AND THE LATE RESULT OF NEUROLYSIS.

Male, æt. 23, on March 4th, 1904, caught his left arm between the rollers of a planing machine. When seen four weeks later his only complaint was of altered sensation in the radial area of the hand. At this date there was considerable bruising at the inner side of the arm, and the forearm was held midway between pronation and supination with flexion at the elbow, the wrist being dropped. Pronation, supination, and full extension were impaired. The supinator longus and extensors of the wrist, fingers, and thumb were not acting, but did not give the reaction of degeneration; they failed to respond to the interrupted current, but reacted well to the constant current, though less briskly than on the sound side and to a smaller current, and there was no polar reversal. He was treated by splint and massage for four weeks, but as no improvement took place he was operated upon. An incision to the outer side of the biceps tendon showed that the supinator longus and extensor carpi radialis longior were lacerated and torn from their origins. The nerve was densely embedded in fibrous tissue, but its anatomical continuity was uninterrupted. The muscles were sutured into position and the freed nerve surrounded with oiled silk; the wound was closed and drained by a tube. The oiled silk came away six weeks later. Three and a half months after this operation voluntary power returned to the wrist and fingers, but at this date there was no reaction to the interrupted current. These muscles improved rapidly, but did not react to the interrupted current until six months from the date of operation.

CASE 3 .-- SHOWING THE LATE RESULT OF SECONDARY SUTURE OF THE MUSCULO-SPIRAL NERVE.

Male, æt. 9 (July 28th, 1903), came under observa-tion, at the Poplar Hospital for Accidents, with paralysis of all the muscles of the forearm supplied by the musculo-spiral nerve, these muscles giving the reaction of degeneration. On June 28th he had fractured the lower third of his humerus. This had been reduced by open operation; the paralysis "was noticed several days later.

An operation on August 3rd showed that the nerve had been completely divided with about } in, separation between the ends; the ends were sutured, and the wound healed by first intention.

The first trace of recovery was seen seven months after the suture; the carpal extensors acted voluntarily and reacted to the interrupted current. Three months later (ten months from the date of operation) all the muscles supplied by the nerve acted voluntarily and reacted normally.

CASE 4.—SECONDARY SUTURE OF THE MEDIAN NERVE THREE

MONTHS AFTER DIVISION, SHOWING A STAGE IN RECOVERY.

A male cook, æt. 34, fell from his bicycle July 10th, 1907, and put his hand through a glass window. He immediately went to a hospital and had the skin wound sutured without an anæsthetic. Three months later, light touch was lost over the usual median area, prick could not be felt over the terminal phalanges of the index and middle fingers, and scars of ulcers and blisters, due to his work, were present over the analgesic area. Previous to the nerve section he had not gave the reaction of degeneration.

On October 16th, 1907, operation showed an inch separation between the ends of the nerve; the ends were freed, freshened, and united with fine chromic gut. Recovery had followed the usual stages. Nine months after suture there was no return of motor power or change in the electrical reactions, but anal-gesia had gone, whilst sensation to light touch was returning.

CASE 5 .- ILLUSTRATING THE LATE RESULT OF PRIMARY SUTURE OF THE MEDIAN NERVE AT THE WRIST.

Male, æt. 21 (October 2nd, 1902), cut his right wrist with a knife; he immediately felt numbness in the thumb, index and middle fingers. Primary suture had been performed the following day, and he had been kept under observation and his recovery watched, stage by stage, for four years. Three years after the

date of the primary suture he said that the hand was as well as it was before the accident. When exhibited he did not know any difference from the other hand except in cold weather. It did not interfere at all with his work as a butcher. There was still slight wasting his work as a butcher. There was still slig of the outer group of the thenar muscles.

CASE 6 .- : NJURY OF THE MEDIAN NERVE FROM AN UNUSUAL CAUSE, WITH THE FORMATION OF TROPHIC BLISTERS.

Male, æt. 36, on December 11th, 1908, fell 9 or 10 ft. from a window-sill and hurt his hand, probably by a fall on the outstretched palm. He immediately noticed loss of sensation in the index and middle fingers. Eight weeks ago he put his hand into water, not uncomfortably hot for the sound fingers, and produced blisters on both surfaces of the index and middle fingers and the palmar surface of the terminal phalanx of the thumb. These areas were still insensible to prick and to light touch when examined on February 26th for the first time. The hand was held with the thumb in the median position, with its metacarpal bone somewhat extended and closer to the index finger than normal. The abductor and opponens pollicis muscles were weak but acting. The abductor did not react to the interrupted current, but reacted in a manner typical of incomplete division to the constant. The opponens reacted to the interrupted current. A thickening could be felt in the median nerve immediately above the annular ligament. This case was regarded as an example of injury to the median nerve below the point at which its palmar cutaneous branch is given off. CASE 7.—DIVISION OF THE ULNAR NERVE BELOW ITS DORSAL BRANCH.

Male, æt. 24, sustained an incised wound of the wrist on October 28th, 1908, dividing the ulnar nerve below the point at which its dorsal branch is given off. Primary suture was performed the same day. February 11th, 1909, the loss of sensibility to prick had disappeared, but no change had taken place in the area of loss of light touch, which was as extensive and as well defined as immediately after the accident. All the intrinsic muscles of the hand supplied by the ulnar herve were paralysed and gave the reaction of de-

CASE 8.—COMPLETE SECTION OF THE ANTERIOR PRIMARY
DIVISION OF THE FIFTH CERVICAL NERVE, TOGETHER WITH OR ABOVE THE NERVE TO THE RHOMBOIDS.

On July 31st, 1905, this patient fell off a wall on to some railings, a spike of which penetrated his neck. The wound was sutured the same day at an infirmary, without an anæsthetic. On October 18th. 1905, all the muscles supplied by the fifth cervical rerve were paralysed, and the reaction of degeneration was present in those which could be tested. Loss of was present in those which could be tested. Loss of sensibility was present in the area supplied by the descending branches of the cervical plexus and by the fifth nerve. On October 25th Mr. Hutchinson explored the plexus in the neck. The distal portion of the fifth was united with what appeared to be its central end. The other roots of the plexus were seen to be normal.

When exhibited there was no loss of sensibility, but he showed no sign of motor recovery; all the affected muscles were still paralysed, and give the reaction of degeneration. The deformity resulting from paralysis of the rhomboids was well shown.
CASE 9.—CHRONIC NEURITIS OF THE ULNAR NERVE DUE TO

DEFORMITY IN THE REGION OF THE ELBOW, TREATED BY RESECTION OF THE DAMAGED PORTION OF THE NERVE.

A tailor, æt. 36, showed marked deformity in his left elbow, evidently due to epiphyseal injury in early For seven months before coming under observation in June, 1904, he had noticed weakness of the hand and pain in its ulnar area, increasing in severity and preventing him from following his employment. There were loss of sensation and paralysis in the distribution of the ulnar nerve, and wasting of muscles. The ulnar nerve could be felt enlarged in a spindle-shaped manner behind the internal condyle; it was not manner behind the internal movable laterally to any extent.

On June 17th, 1904, the spindle-shaped swelling was excised, 13 in. of the nerve was removed, and then the rerve was sutured. Recovery followed the usual stages, but was not perfect. The hand was still in the "ulnar" position, with marked wasting of the intrinsic muscles supplied by the ulnar nerve, but they were acting, and he had gone back to work on full wages.

CASE 10.—CHRONIC NEURITIS OF ULNAK NERVE IN THE REGION OF THE ELBOW.

C. W., a carman, æt. 42, came under observation at the London Hospital, February 26th, 1909, on account of wasting of the muscles of the left hand. He had noticed a gradual loss of power in the hand for a year, and for six or seven months the little and ring fingers have been "getting bent up."

The fingers were held in the "ulnar" position; all the muscles supplied by the ulnar nerve were wasted, paralysed, and gave the reaction of degeneration. There was impairment of light touch over the ulnar area of the hand. The ulnar nerve was very prominent behind the internal condyle, and was enlarged in a spindle-shaped manner. Full extension of the elbowjoint was impossible, and there appeared to be some bony thickening beneath the ulnar nerve. X-ray examination showed changes due to osteo-arthritis.

Mr. A. H. Tubby showed three cases of

NERVE GRAFTING. Case 1, that of a patient in whom facial hypoglossal junction had been performed, for division of the facial nerve during the opening of an abscess. Case 2, that of a boy with infantile paralysis, in whom the internal and external popliteal nerves had been grafted. Case 3, that of a man who had been the sub-ject of a total lesion of the right brachial plexus, and consequent fibroneuroma of the fifth cord. This cord

had been grafted into the sixth.

Mr. C. H. FAGGE showed a case of
INFLAMMATORY FACIAL PARALYSIS: TREATED BY FACIAL ACCESSORY ANASTOMOSIS.

Male, æt. 45. Complete left infranuclear facial paralysis had followed an attack of middle-ear suppuration. In December, 1907, the nerve had been exposed and stimulated with non-polarisable electrodes, but as some contraction of the facial muscles had resulted, nothing was done. Electrical treatment had been continued without benefit for three months, so in March, 1908, the facial nerve had been again exposed and divided at its exit from the stylomastoid foramen. It was then found not to be long enough for suture into the hypoglossal without undue tension, so the trapezial portion of the spinal accessory was divided in front of the sternomastoid and an end-to-end union made between it and the distal end of the facial. Electrical treatment was continued and improvement began. Photographs taken six months later show that movements of the left side of the face were best carried out when the left arm was raised.

Mr. C. M. PAGE showed for Mr. Ballance a case of SUTURE OF THE INTERNAL AND POSTERIOR BRANCHES OF THE BRACHIAL PLEXUS.

Female. æt. 21, in July, 1906, had sustained a comminuted fracture-dislocation of the upper end of the humerus, associated with injury to the posterior and internal branches of the brachial plexus. Two months after injury these had been sutured. Recovery of function of the musculo-spiral nerve had followed, and recovery of sensation in the distribution of the

Mr. W. McADAM Eccles showed a case of

CHARCOT'S DISEASE OF THE RIGHT ANKLE-JOINT.

Man, æt. 29, a greengrocer, who denied syphilis and venereal disease, was admitted to hospital with swelling of the right ankle-joint of six months' duration, and a provisional diagnosis of tuberculosis of the joint. But on further investigation it was found that he pre-But on turther investigation it was found that he presented evidence of tabes dorsalis, as shown by the absence of knee-jerks, presence of pupil phenomena, and lightning pains down both lower extremities. The right ankle is completely disorganised, and the skiagram shows extensive alteration of the adjacent articular surfaces of the tibia and astragalus.

Mr. W. R. BATTLE asked whether in consequence of the age of the patient the case was thought to be one

of congenital or acquired syphilis?

Mr. RAYMOND JOHNSON suggested the diagnosis of syringomyelia in view of the presence of lateral cur-

Mr. Eccles, in reply, said that there were no signs of congenital syphilis. There was no dissociation of sensations.

Major C. G. SPENCER, R.A.M.C., showed a case of SARCOMA TREATED BY INJECTIONS OF COLEY'S FLUID.

Male, æt. 33. Admitted in August, 1906, with a large growth in the lower part of the abdominal wall, infiltrating the recti, attached to the pubic symphysis. and extending down in front of the bladder so that it could be felt per rectum. A piece of the tumour had been removed for examination, and was reported to be a spindle-celled sarcoma. An attempt to remove the growth having failed, owing to wide involvment of the peritoneum, injections of Coley's fluid were com-menced on September 22nd, 1906. Since the end of March, 1907, he has not had any further treatment; the tumour has completely disappeared, and he has continued in perfect health.

Mr. WALTER SPENCER said that he had experience of two cases of new growth treated by Coley's fluid. One was a case of sarcoma in the neck, which had been frequently operated upon; the other a case of fibrosarcoma of the sheath of the femoral artery. In both cases the growth had been held in check.

Mr. PEARCE GOULD said that in the Middlesex Hospital cancer wards he thought that most of the cases had not been benefited by this method. It had, however, been tried some time ago, and possibly the fluid had not been quite correctly prepared. He had never had a case comparable to that shown by Major Spencer.

Mr. LAWRIE McGAVIN showed a case of PERINEAL HERNIA.

A widow, æt 36, for two years had complained of dragging pain, resembling a labour pain, in the right iliac fossa, and for nine months had felt a movable "lump" in the abdomen. A swelling in the ischio-rectal fossa had been discovered, which was quite small and easily reducible. Six weeks ago the patient returned with the hernia very much larger, but she did not have any inconvenience referable to implication of the pelvic organs in the hernia. When the mass had been reduced, a gap admitting two fingers can be felt in the central portion of the levator ani muscle, the hernia coming down alongside of the vagina and rectum, through either of which the impulse on coughing could be detected.

Mr. STANLEY BOYD had seen a case which had been diagnosed as one of hernia in the ischio-rectal fossa. This had proved to be fat. He had removed a large quantity, and found that the finger could be put through a hole in the levator ani. He knew of another case of the same nature.

Mr. A. E. BARKER could recall a case like that shown. He doubted whether it was a hernia, but considered it more probably a lipoma.

Mr. H. Goodwin showed a case of

"BUTCHER'S STREPTOCOCCUS."

The wife of a butcher scratched the terminal phalanx of her index finger. Four days later the finger became erythematous and cedematous; the next day the condition had spread to the wrist, and there was much cedema of the dorsum of the hand. Incision of the swelling gave exit to sanious serum containing streptococci, and next day the condition appeared cured. Five days later a patch of erythema with an œdematous margin returned; cultivation showed a streptococcus, and the patient was treated with a vaccine in doses increasing up to 1,000 million. The patches, however, gradually spread until the whole chest was covered after an interval, during which the condition appeared to be arrested, it appeared on the ankle, and has spread above the knee. Bier's method was employed, but vaccine treatment was not tried again. In November the discharge was sterile. The application of Xrays for ten minutes twice a week has appeared to do good, but the patches continue to spread.

Dr. OFENHEIM showed three cases of

SEPTICÆMIA TREATED BY VACCINE THERAPY.

Case 1, Nurse S., finger was infected from a case of otitis media. Whitlow in left thumb on February 20th, 1908, and or. March 5th general septicæmia had followed. Several incisions were made. Cultures from the pus yielded staphylococcus aureus and streptococcus pyogenes, and cultures from the blood showed S. pyogenes in pure culture. From the latter a vaccine

was made and inoculations given under constant con-

trol of the opsonic index.

Case 2, Mrs. X., was delivered of a stillborn child on January 27th, 1908, after version for placenta prævia. Admitted to hospital on February 5th with rigors, sickness, diarrhoea, and profuse vaginal discharge. Temperature from 101° to 103° F., pulse 110-112. On February 10th cultures from the vaginal discharge and from the blood were taken. The former grew S. pyogenes and a few colonies of bacillus coli communis; the latter grew S. pyogenes in pure culture. On February 18th patient received the first inoculation from her own vaccine. The patient was discharged quite well on March 12th.

Case 3, male, admitted on March 18th, 1908, with supposed enteric fever, after having been bitten by a rat on the left thumb five weeks previously. He had a few rigors, headache, dry furred tongue, an erythematous rash, and a temperature varying between 99° and 104° F. On March 29th cultures taken from some erythematous patches, after scratching the skin, grew micrococcus tetragenus. A vaccine was made from this organism, but the patient did not show any improvement after two inoculations. Indices could not be taken, because his serum agglutinated blood-corpuscles at once, even in dilutions of 1 in 60, and the agglutination test was negative. On March 24th a blood-culture again grew the same organism, whilst previous blood-culture had remained sterile. Inoculations were resumed, and given until July 6th, from which day patient was in perfect health. M. tetragenus frequently co-exists with tubercle bacilli in pulmonary tuberculosis as a non-pathogenic organism. About 42 cases are on record in foreign literature in which M. tetragenus showed pathogenic action. It is frequently found in rats and mice, producing septicæmia in these rodents.

Dr. H. D. ROLLESTON showed a case of LYMPHADENOMA WITH VARYING JAUNDICE.

Girl, æt. 7, had enlarged glands on both sides of the neck and in both axillæ; one of the glands had been excised and showed the histological appearance of lymphadenoma. The liver and spleen were enlarged. At irregular intervals of from a week to a fortnight the patient had febrile attacks, with increase in size of the glands and liver and very definite jaundice. Presumably the jaundice was due to pressure exerted by lymphadenomatous intra-abdominal glands on the bile-duct, probably in the portal fissure, as no enlargement of the gall-bladder had been detected. Between the febrile attacks the jaundice diminished, but now did not disappear.

did not disappear.
Dr. A. E. Wynter showed a case of PULMONARY STENOSIS.

Female, at. 16, had rheumatism at 12 years of age, and occasional sharp pain in left submammary region during the past four years. She became dyspnœic on exertion and swelling of the face and abdomen was said to have occurred at times. A systolic murmur was audible at the left third chondro-sternal junction, and was conducted upwards towards the left clavicle. The superficial cardiac dulness was only slightly increased to the right apex beat in normal position. Complexion was pale with crimson lips.

Dr. A. E. Wynter also showed a case of INFANTILE PARALYSIS: PARAPLEGIC DISTRIBUTION WITH INVOLVEMENT OF ABDOMINAL MUSCLES ON THE LEFT SIDE.

Male, aged 6 months, breast-fed. No previous illness. Shortly after a fall on December 5th, 1908, the patient had a fit and was soon after observed to be paralysed. Protrusion of the left side of the abdomen was noticed about December 18th. He was admitted to Middlesex Hospital, January 30th, 1909.

Dr. A. E. Wynter also showed a case of CURE OF ASCITES BY PERMANENT DRAINAGE THROUGH THE

FEMORAL RING.

Male, æt. 50, was admitted on September 14th, 1908, for ascites associated with hepatic cirrhosis. For six weeks attempts were made to reduce the ascites by drugs. It was then found necessary to remove the fluid by paracentesis, but it recurred within a fortnight. In the middle of November Mr. J. Murray opened the femoral canal, inserting a decalcified bone tube, and fluid continued to drain away for three weeks. Since the healing of the incision the patient

had been getting about, and there has been no further need for paracentesis.

Dr. A. E. GARROD read a short paper on a case of URÆMIA OR MENINGITIS.

It was that of a boy who had been admitted to the Hospital for Sick Children, Great Ormond Street, because he had been passing black urine. There was no history of a decreased quantity of urine being passed. When seen on admission, he lay curled up, and resented disturbance. He spoke, if questioned, but was occasionally incoherent. He was pale and emaciated. The pulse-tension was equal to 125 m.m. of mercury. The urine contained blood and a dense cloud of albumin. About 325 c.c. were passed in the first 24 hours. Granular and blood casts were present. There was considerable general tenderness. The abdomen was retracted. The knee-jerks were increased, and ankle-jerk was obtainable on the right side. The left plantar response was extensive, the right was not obtained. Kernig's sign was present on both sides. No optic neuritis was present.

The next day the head was retracted, there was active delirium, and the boy was incontinent. Treatment was started as for uræmia. Varying rigidity—lasted until the 8th day, when improvement started and continued until complete recovery ensued. For a few days the amount of urine was considerably diminished. With recovery the albumin gradually lessened and finally disappeared altogether from the urine. A lumbar puncture had been unsuccessful in

obtaining fluid.

He thought the case was one either of meningitis or uræmia. If meningitis, it was probably meningo-coccal in origin. Koplik had described nephritis as occurring in that disease. If meningitis, it must have been very slight, and the rapidity of the convalescence was unusual. In favour of uræmia, cases had been described in which symptoms like meningitis had occurred, but in these the convalsions had been clonic, not tonic. Weiss had recorded two cases diagnosed as tuberculous basic meningitis which proved to be chronic interstitial nephritis.

Dr. PARKES WEBER asked whether he had noticed that tapping the muscles led to an extreme degree of muscular contraction? He had had a case of extraordinarily exaggerated tendon reflexes preceding uramic

oma.

Dr. H. D. ROLLESTON suggested that possibly this case might be influenzal. The kidneys were occasionally considerably affected in that disease.

Dr. G. A. SUTHERLAND said that similar symptoms occurred in middle-ear disease. He agreed with Dr. Garrod that uræmia was the most probable diagnosis. He compared these symptoms to those sometimes seen in cases of pneumonia.

The PRESIDENT said that a combination of hæmorrhagic nephritis and cerebral symptoms occurred sometimes in acute diseases, and the prognosis in such cases was not always bad. It was also true that exactly such symptoms were seen with otitis media. In uræmia, where there was much rigidity and irritability, and where convulsions were present, he found that the absence of Babinski's sign was of great value.

symptoms were seen with otitis media. In uræmia, where there was much rigidity and irritability, and where convulsions were present, he found that the absence of Babinski's sign was of great value.

Dr. Garron, in reply, said that he had not noticed any particular effect by tapping the muscles. It was highly probable that the case was one of acute infection, but there was no particular indication that it was due to influenza; moreover, black urine was passed long before the child was acutely ill. Examination of the ears had revealed no abnormality. He had often noticed earlier recovery in cases of nephritis when the blood passed was proportionately greater than the albumin.

Dr. Macnaughton-Jones read a paper on

CANCEROUS TUMOUR OF THE SPINAL MENINGES, INVADING
THE CORD AND CAUSING PARAPLEGIA, SECONDARY 50
MAMMARY CARCINOMA.

At the last meeting of the Departmental Committee of the Privy Council to inquire into the working of the Midwives Act, evidence was given by Dr. A. Robinson, Medical Officer of Health for Rotherham: Sir George Fordham, Treasurer of the Central Midwives Board; and Mrs. Heywood Johnstone. President of the Rural Midwives' Association.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MARCH 3RD, 1909.

The President, Dr. JAMES RITCHIE, in the Chair.

MR. J. W. DOWDEN showed: (1) A man on whom he epithelioma of the lip. The glands were thoroughly cleared out 10 days after the tumour was excised. There had been no recurrence. It was advisable to perform such operations in two stages, in order to lessen the risk of lymphatic infection in removing the cancer. (2) A patient, nine months after interscapulo-thoracic amputation for recurrent sarcoma of the deltoid.

Mr. ALEXIS THOMSON showed (1) two cases of internal derangement of the knee-joint. It was not possible, except in typical cases of displacement of the anterior end of the semi-lunar cartilage, to say beforehand what the exact cause of locking was, hence it had been necessary to open the joint freely by transverse division of the ligamentum patellæ. In one case the posterior end of the internal semi-lunar cartilage was found to be thickened and frayed; in the other a tag of cartilage depended from one of the crural ligaments. In both patients good power of extension was present, although the ligamentum patellæ had been divided. (2) A girl who, as the result of an extensive burn in childhood, had acquired an extreme degree of flexion contracture at the elbow and wrist. This had been relieved by resection of both the elbow and wrist-joint, and by the grafting in the flexion aspect of each joint of a flap taken from the anterior abdominal wall.

Dr. EDWIN BRAMWELL read a paper on THE PROBLEM OF THE SANE EPILEPTIC.

His object in bringing the question before the Society was to arouse interest in the matter, because in Scotland there was no provision made for such patients. He did not think there was any ground for supposing that epilepsy was less frequent in Scotland than in England. During six years he had collected notes of over 70 cases at the Leith Hospital out-patient department, out of a population of about 80,000. He pointed out that epilepsy hampered patients as children in relation to education, and as adults in relation to work. Many of the cases he saw were comparatively well in the intervals, and yet, on account of the disease, they had the greatest difficulty in getting work. The difficulty was greater now than formerly on account of the operation of the Workmen's Compensation Act. He described the working of the epileptic colony, which he regarded as fulfilling the needs of these patients better than any other method of institutional treatment. In Scotland a small epileptic colony had been started by the late Mr. Quarrier, but, with this exception, the country had been extremely backward in dealing with

this class of the community.

Dr. Dunlor thought that epileptics should be under the care of the lunacy authorities, and objected to colonies on the ground that insane epileptics tended to accumulate there, and to escape the supervision of the Lunacy Commissioners. He regarded so-called "sane epileptics" as forming a small percentage of the whole, and thought that they should be dealt with under the Poor-law

Dr. Byrom Bramwell, and several other speakers supported the view that epileptic colonies should be provided, and it was pointed out that Dr. Dunlop's criticism was directed against the administration, not against the principle. Proper medical examination and transference of patients to asylums as soon as mental deterioration set in would prevent colonies becoming unlicensed asylums.

Mr. ALEXIS THOMSON read a paper on

THE DIAGNOSIS AND TREATMENT OF CHRONIC ULCER OF THE STOMACH AND DUODENUM,

which will be found on page 263 of our present issue. Professor Caird, Mr. C. W. Cathcart, and others discussed Mr. Thomson's paper.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY

MEETING HELD FRIDAY, FEBRUARY 19TH, 1909.

Mr. SETON F. PRINGLE in the Chair.

ŒSOPHAGEAL DIVERTICULUM.

MR. WILLIAM TAYLOR read the notes of a case of œsophageal diverticulum, which he had removed from a gentleman in June, 1908. The patient was fifty-four years of age, and his symptoms dated back for about twenty years. The symptoms had been gradually getting worse. Food was usually regurgitated into the mouth just as it had been eaten, sometimes almost immediately, at other times after several hours. Not immediately, at other times after several nours. Not unfrequently portion of the previous night's supper was regurgitated next morning while in the bath. Pills taken at night were frequently regurgitated unchanged next morning. A feeling of fullness and discomfort after eating was generally referred by the patient to the right side of the neck, about the level of the hyoid bone. Attempts to pass bougies failed their passage being arrested about nine inches from the teeth, but their passage seemed to be arrested more from spasm of the œsophagus than from encountering any other source of obstruction. There was no swelling to be detected on inspection of the neck. [A beautiful radiogram of the pouch filled with bismuth food was taken by Dr. Watson and shown at the meeting, as well as the pouch itself. Through the "screen" before the photo was taken each bolus of food the patient attempted to swallow was seen passing into the pouch.] The pouch took its origin from the left side of the esophagus just at its junction with the pharynx, and passed downwards behind the esophagus, to terminate at a point just below the supra-sternal notch. The diverticulum was removed through an incision extending from the hyoid bone along the anterior border of the left sternomastoid muscle to the sterno-clavicular articulation. The anterior belly of the omohyoid muscle and the superior thyroid vessels were divided. The lateral lobe of the thyroid gland, which was considerably enlarged, was displaced, after which the diverticulum was readily seen and withdrawn, there being no adhesions. Two small intestinal clamps were applied, and the diverticulum removed by dividing between them. The opening into the esophagus was closed by three rows of fine silk sutures. A small tube was passed from the centure of the wound in the neck down to the region of the sutured œsophagus, and a piece of gauze loosely packed around it. About three-quarters of the neck-wound was closed. The wound healed by first intention, unless where the drainage had been applied, but even that was healed up by the end of twelve days. There was never at any time any sign of leakage from the œsophagus. Nourishment by the mouth was withheld for four days. Rectal salines, with raw meat juice, were administered every six hours. Nourishment was given by the mouth on the eighth day, and gradually increased in amount and in consistency until a lamb chop was easily partaken of on the sixteenth day. The patient is now in perfect health, and has no difficulty in swallowing.

Mr. Taylor then briefly discussed the literature of

the subject.

The CHAIRMAN said the case was one of the first, if not the first, of such cases reported to the Academy. He wished to know if the œsophagus had been examined since with the bougie, and if the spasm had disappeared.

Dr. MAGEE FINNY said the patient was under his observation for some years, and as far back as 1903 it was thought he had something of a pouch about his throat. It was a great worry to him, and seemed reflexly to produce nervous irritation and dyspeptic phenomena. One could not forecast how long it would be safe to allow a patient who had a diverticulum to go without operation. It was interesting how the diverticulum could swell out and prevent a tube passing, and yet did not prevent the tal g of food and drink. At his suggestion, Dr. Watson tried a meal of bread and milk for making a radiograph, and obtained excellent results. The same method had been tried on a patient approaching eighty years of age, and the radiograph which he exhibited showed a pouch corresponding to that in the former case. A later picture showed a lateral increase, and he would have another one taken shortly. They gave this patient the same mixture as Mr. Taylor used, and they could see it on the screen catching in the pouch and slipping down.

Dr. M'VITTIE referred to a case of dilatation of the cesophagus, brought about by spasm, in which the patient was dying of starvation. By the use of Russell's œsophageal stricture dilator, which he

exhibited, the patient was completely cured.

Mr. L. G. Gunn said he had a case which seemed an ordinary case of carcinoma of the œsophagus. He did a gastrostomy, and did not think the patient would live long. Thirteen months afterwards he saw him again, looking well, and having put on weight He then thought he had a diverticulum obstructing the gullet. Dr. Woods examined the case with the œsophagoscope, and snipped away a small portion of the stricture, which proved to be a carcinoma.

Mr. R. A. STONEY mentioned a case in which the diagnosis lay between malignant disease and some simple stricture of a syphilitic nature. He opened the stomach, which was small and adherent, and fed with a tube from the mouth to the stomach. Later he had to do a duodenostomy, and lost sight of the

Mr. TAYLOR, in reply, said he had not passed a bougie since the operation was done. The condition was not usually noticed until a surgeon questioned the patient, when it was not unfrequently found that the symptoms began about thirty to forty years of age. His patient dated his symptoms back twenty years. Esophageal pouches of a pressure type were met with always at the junction of the pharynx and œsophagus, and he was convinced that, unless in extreme cases, the shadows in a radiograph would not extend below the pericardium.

SUPRA-PUBIC PROSTATECTOMY.

Mr. L. G. Gunn read a paper on complications following on supra-pubic prostatectomy. He detailed his experience of the operation, and mentioned especially as complications fistula, impotence, persistent cystitis, formation of stone, persistence of some frequency of micturition, impaired power of the

requency of micturition, impaired power of the compressor urethræ muscle, and anæmia. The Chairman recalled a troublesome case of fistula, and thought it was not wise to tie in the catheter. A fistula would close rapidly, but as soon as the catheter was taken out the scar tissue would re-contract. For a few days after operation he generally used suction apparatus. He had come to look on hiccough in a prostatectomy case as a sure precursor of death.

precursor of death.

Mr. Wm. TAYLOR said he had recently been thinking whether they were not foolish in sticking to the suprapubic method, and not removing the prostate by the perineal route. Mr. Young's statistics showed 110 cases done in succession without a single death, and in 146 cases there was only one death. His own mortality was 8 per cent. to 10 per cent. He looked on the use of scissors as more or less unsurgical even on the use of scissors as more or less unsurgical even under one's eye, and to use them blindly did not appeal to him. Among the complications following the operation he had seen senile gangrene arising, he believed, from a weak heart. He had also seen pelvic cellulitis follow, and he had seen a patient die apparently of hæmorrhage and shock. He had found that cases in which he did not use suction apparatus that cases in which he did not use suction apparatus did as satisfactorily as the ones in which suction was required. He now used nothing but a pad of wool, and the results were satisfactory. He looked on hiccough as a sign of uræmia, and consequently a

fatal sign.

Mr. Gunn, in reply, said the less appliances they had the better. He thought it was hardly fair to take the statistics of one man, who was an expert at an operation, and selected his cases carefully. American statistics were not as good as the general English statistics, and impotence and troubles of a similar kind must be more frequent after the perineal than after the supra-pubic operation. He thought it was better surgery to pass a curved scissors and cut through the sutures than to drag them with the finger. In two cases of Bottimi's operation which he had seen the results were completely satisfactory.

# WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MARCH 5TH, 1909.

The President, Colonel T. H. HENDLEY, in the Chair.

DR. E. FURNISS POTTER read a paper, illustrated by lantern slides, on

THE SUBMUCOUS RESECTION OPERATION FOR THE REMOVAL OF DEVIATIONS AND OBSTRUCTIVE DEFORMITIES OF THE NASAL SEPTUM.

Dr. Potter showed that what were formerly regarded as purely ledge-like outgrowths of bone or cartilage, are in reality the thickened angular summits of septal deflections, hence the sawing off of the obstructing spur was frequently disappointing as only a small shaving of cartilage was removed, or else a large perforation made.

Dr. Potter described the operation:—Position.—
Patient lying down, face towards operator. Anastatic: Local.—Plugs of 20 per cent. novocain, with an equal part of 1 in 1,000 adrenalin, placed in each nostril and left in for 30 to 45 minutes. Illumination.—Focal head electric light. Operation.—(1) Vertical incision on the convex side of the deviation in forms. cision on the convex side of the deviation, in front of the deviated portion made from as high a spot as possible through the mucous membrane and carried down to the nasal floor. (2) Mucosa with the perichon-drium deflected from cartilage with an elevator. (3) Vertical cut through the cartilage anterior to portion Vertical cut through the cartilage anterior to portion to be resected. (4) Elevator passed through the slit in cartilage and mucous membrane, cautiously reflected from the concave side. (5) The whole of the mucous membrane being thus reflected from both sides of the cartilage, the cartilage is now removed either with a special swivel knife or punch forceps. and the incisor crest by Killian's gouge (6) If properly performed, the two mucous membranes should hang straight in the middle line of the nose. and each nostril should be plugged with well-vaselined pieces of cotton wool, which may be removed after 24—48 hours, and daily gentle irrigation with alkaline lotion is all the after-treatment required.

Dr. Potter, in conclusion, claimed the following advantages:—(1) The establishment of a free nasal passage attained with certainty. (2) No general anæsthetic required. (3) Rapid healing, no splints or drainage needed. (4) No loss of mucous membrane.

Dr. Wyllie expressed himself as in favour of the intition and the interior.

sitting-up position, and of stitching up the incision

with a special fish-hook-like needle.

with a special fish-hook-like needle.

Dr. Barry Ball reviewed the history of the operation, and emphasised the caution of Dr. Potter's as to the necessity of leaving at least 5 mm. of cartilage beneath the bridge of the nose, lest sinking in of the bridge should take place.

Dr. Davis preferred general anæsthesia to local.

Dr. ASLETT BALDWIN asked whether there was not a leave of the property of the property

danger of a sail-like flapping septum resulting from the operation.

Mr. RICHARD LAKE agreed with Dr. Potter as to the unimportance of celerity as opposed to thoroughness in

the operation?

Mr. Bowen pointed out the importance of firm nasal plugs in preventing the formation of blood-clot between the two mucous surfaces.

Dr. FURNISS POTTER, in replying, did not agree with Dr. Wyllie that the sitting position was the best; had used the special needle, and had abandoned its use: was unable to accept Dr. Davis' suggestion as to general anæsthesia; agreed with Dr. Ball that the operation was not possible before the adrenalin era; and, in reply to Dr. Baldwin, stated the operation resulted in a hard and rigid septum, satisfactory in every way.

## ULSTER MEDICAL SOCIETY.

MEETING HELD ON THURSDAY, MARCH 11TH.

The President, Mr. T. S. KIRK, in the Chair.

Professor Sinclair opened an adjourned discussion on gastric ulcer. He expressed himself strongly in favour of gastro-enterostomy as against excision of ulcers, and was quite satisfied with the results he

had obtained in operating on about 80 cases of ulcer.

Mr. A. B. MITCHELLadvocated again the infolding
of gastric ulcers, an operation which he had originally suggested, and which he still believed to be the best method of dealing with this trouble.

Mr. Robert Campbell drew attention to the fact that one often opened the abdomen and failed to find

on the outside of the stomach any sign of ulceration.

Dr. John MacIlwaine discussed the etiology of the affection. From his experience as Medical Registrar at the Royal Victoria Hospital, he believed in the very close association of anæmia, hyper-acidity of the stomach, and gastric ulcer. He thought there was stomach, and gastric ulcer. He thought there was often great difficulty in deciding into which of these three classes certain cases should be put.

Sir John Byers drew attention to the fact that the ultimate result of gastro-enterostomy for gastric ulcer was often most disappointing. He deprecated promiscuous surgical interference.

Mr. FULLERTON said that he believed in the septic origin of many cases of ulcer. He thought that a trial should be made of excision of the ulcer before a

gastro-enterostomy was advised.

Mr. Howard Stevenson drew attention to the importance which physiologists attach to the passage of food through the duodenum in stimulating pancreatic secretion.

The President insisted that in cases where a laparotomy was done, and no sign of ulcer was seen on the surface of the stomach, the stomach should always be opened and examined. Many of the cases which simulated ulcer were really cases of contraction of the pylorus, and gave better results from stretching of the pylorus than from gastro-enterostomy. This was the class of case where gastro-enterostomy gave such un-

satisfactory results.

Dr. CALWELL, who had opened the discussion at the previous meeting, replied to a number of questions put by previous speakers, and wound up a most

interesting discussion.

A resolution forwarded by the Irish Medical Association (Fermanagh Branch) ,and which has already been printed, was discussed at length. It was finally agreed that, while it was desirable that regular paid health lecturers should be appointed by the authorities, the time was not ripe to insist on pioneer work in health matters being confined to paid officials.

## CORRESPONDENCE.

# FROM OUR SPECIAL CORRESPONDENTS ABROAD.

## FRANCE.

Paris, March 14th, 1909.

TREATMENT OF ANTHRAX

TOTAL extirpation of anthrax had been proposed years ago by Broca and Tielal, and practised once or twice by Labbé and then forgotten. Recently, how-ever, Dr. Mabbini, of Marseilles, reported two cases of extensive anthrax operated on by him with complete

The first patient, suffering from diabetes, presented a voluminous anthrax in the back. Dr. Mabbini removed it completely, and at the end of a month the

wound had entirely healed.

The second patient entered the hospital for a large arithms on the back of the neck. No glycosuria was present. The anthrax was removed under the influence of local anæsthesia by chloride of methyl, and the patient made a rapid recovery. Where the tumour is very extensive, general anæsthesia should be used.

Extirpation, which is completed in three or four minutes, should include not only the diseased parts, but also a small portion of the healthy tissue, the incision being made about a quarter of an inch outside the limit of the anthrax.

A compressive dressing is generally sufficient to arrest the bleeding, but, if necessary, one or two ligatures might be applied. A dressing of oxygen water is renewed every day.

When the granulations attain the level of the surrounding skin-that is to say, in ten days-cicatrisation may be stimulated by touching the parts with natrate of silver or practising grafting, according to the method of Ollier-Thiersen.

The great advantage, observes Dr. Mabbini, of the method, is to bring about a fall of the temperature when it exists, and to arrest the general symptoms, as a wound, eminently septic, has been transformed into a normal wound, which will heal normally, and from which all fear of infection is removed—a fact of no mean importance in cases of diabetic patients.

The classical method of incision followed by Spaay is tedious, and the persistence of a septic wound might produce phenomena of resorption frequently mortal. Further, the healing process requires from four to six weeks, whereas by the method of extirpation the dura-

tion does not exceed 25 days. TREATMENT OF HEMATEMESIS.

The treatment of hæmorrhage of the stomach comprises delicate and complex indications. The gravity of the immediate accidents and the tendency to col-lapse, renders necessary very energetic treatment. On the other hand, the necessity of complete rest of the stomach is an obstacle to the administration of the drugs usual in such cases. Yet absolute rest is nevertheless a fundamental condition for the arrest of the hæmorrhage.

Rest in bed is consequently the first condition, with the head low and the legs drawn up, motion or speaking forbidden, while all solid or liquid food is suppressed for three or four days, after which nutritive enemas might be given, and if the thirst is not suffi-ciently relieved, a few injections of artificial serum are administered, or the patient allowed to suck pieces of ice. When the patient or those around him revolt against this continued abstension, a little iced milk or cold beef tea might be allowed.

As to the application of ice externally, Dr. Plicque, who is an authority on gastric affections, considers that if it is useful in average cases, and especially where the hæmorrhage has a tendency to repetition, the local application of ice where patients are very weakened by the abundance of the hæmorrhage in-

creases the tendency to collapse.

MM. Tripier and Bouvert recommend a directly opposite method to produce vaso-constriction. They employ enemas of hot water (104° F.), which act both on the hæmorrhage and the fainting condition. The method renders great service in grave cases, and especially when ice cannot be had. The enemas are given twice a day for two or three days, and then once a day for several subsequent days. In extremely grave cases ligatures might be placed at the root of the limbs. They are not only useful against the hæmorrhage, but also diminish the sensation of fainting so frequently experienced.

As to drugs, ergotin or its alkaloid, given in subcutaneous injections, are the most frequently employed.

Adrenalin is best given by the mouth:—

Sol. of adrenalin, 12 drops.

Water, 2 oz.

A teaspoonful every five minutes for four or five doses, afterwards every ten minutes.

Injections of morphia are very useful, as they relieve the pain and burning sensation which accompany hæmatemesis.

Numerous other drugs are employed against gastric hæmorrhage; perchloride of iron, ferropyrin, antipyrin, ergot of rye associated with opium, subnitrate of bismuth, chloride of calcium, or chlorate of soda (cancer).

As to a surgical operation, Dr. Picque believes that if theoretically it can be justified, practically, it gives poor results. In such cases, either the hæmorrhage has ceased or the patient has succumbed before surgical aid is at hand.

As soon as immediate danger is averted, attention should be turned to the cause of the hæmorrhage, ulcer, cancer, atrophy of the liver (varicose veins of the œsophagus), and should be treated accordingly.

THE RATIONAL TREATMENT OF CEREBRO-SPINAL

MENINGITIS.

As soon as vomiting, headache, stiffness of the neck, and the Kernig sign are observed, lumbar puncture should be performed. If pus issues, an ounce and a half should be drawn off and replaced by an injection of an ounce of antimeningitic serum of Wassermann or Dopter. The operation should be renewed for three or four days in succession, or until a complete cure, which occurs in 70 per cent. of the most favourable

GERMANY. Berlin, March 14th, 1909

HYPERNEPHROMA OF KIDNEY.

At the Medical Society, Hr. W. Levy showed a kidney that contained in the upper pole a hypernephroma. The patient was first attacked with hæmorrhage from the kidney in August, 1907, from that time for nearly a year it occasionally returned. could be felt over the kidney. By the cystoscope blood was seen coming from the left ureter. No shadow of a stone was seen by Röntgen illumination; tubercle bacilli was not found in the urine, and test inoculation also had a negative result. As the patient, however, had some attacks of renal colic in January last, he consented to undergo an operation, took place on the third day from collapse.

A second preparation shown was a pylorus removed for carcinoma. The patient was a man, æt. 54. Although the man was fat, and the abdominal walls were tense, a tumour could be felt sufficiently distinctly. The tumour was removed completely, the sections being made through parts that were healthy. He died some weeks later from cerebral symptoms; which were supposed to be due to a fracture of the skull that had

taken place a short time before.

Hr. Orth communicated some details regarding a

NEEDLE SWALLOWER,

obtained at the autopsy on an elderly unmarried woman. The woman had spent 18 years of her life in the poor-house at Colber, and there she showed a passion for inserting sewing needles under the skin, a large number of which were removed during the course of years. Some months ago an abscess formed in the neck, which opened and led to the formation of a fistula; at the same time difficulty of breathing came on. In the Röntgen figure eight reedles were seen at the base of the tongue, lying in various directions. On account of the bad general condition of the patient, no attempt was made at removal. She died shortly afterwards of pulmonary phthisis. The autopsy revealed numbers of needles in the skin as well as in the internal organs, and one in each of the following: the liver, the mesocolon, the throat, the right heart, and in the aorta. The speaker considered that the needles, which were found mostly in the organs of digestion, were swallowed, and this was afterwards found to have been the case. Except in the throat, no pathological changes were observed in the parts where the needles lay; the most remarkable thing was that no changes appeared to have been caused by the needle in the aorta except at one spot, where it had become slightly rusty, and where there was a small thrombotic deposit, and this notwithstanding the fact that the needle had penetrated transversely through the whole thickness of the vessel, and remained in that position. This confirmed in the human subject what had been stated in respect to animals by Eberth and Schimmelbusch-viz., that foreign bodies only caused clotting in blood vessels when they presented a roughened surface; fine threads became covered by thrombi, but smooth glass needles did not.

Hr. v. Hansemann showed 704 foreign bodies, nails, needles, and the like that had been found in the stomach of a girl who had tried to commit suicide, and, as this had not been successful, had taken

phosphorus. Not the slightest trace of injury was found in the walls of the stomach, except for a perforation; and such were only to be met with at the cardia, or the pylorus, or in the intestine, as in these spots the walls in contracting thrust aside the soft contents.

Hr. Senator had seen a piece of glass that had worked its way from the stomach by suppuration; it must therefore have penetrated the stomach wall.

At the Surgical Society Hr. Busch showed three cases

of obstruction of the bowels. One was a case of strangulation from a band. The bowel, which was not free from suspicion, was drained by a tube, the abdominal wall suppurated, and a fæcal fistula resulted, and a large piece of small intestine, with mesentery, protruded through the opening; the anus præternaturalis that had formed in this way had to be closed, but recovery finally took place. The second was a case of invagination in a child, four years of age; the invaginated portion could be withdrawn; on its base was a Meckel's diverticulum, which was removed; pancreatic tissue was present in the walls. The third was a case of ileus caused by a Meckel's diverticulum.

## AUSTRIA.

Vienna, March 14th, 1909.

Asthma.

HOFBAUER presented four cases of asthma bronchiala whom he had treated successfully by a method he described to the members of the Gesellschaft der Aerzte two years ago. These cases, he said, had stubbornly resisted the usual methods adopted of rubbing in iodine, giving potassium iodide, atropine, morphia, etc., but with no benefit or relief to the patients. He therefore resolved to apply his gymnastic respiration, with immediate relief. The treatment patients. He therefore resolved to apply his gymnastic respiration, with immediate relief. The treatment consists in teaching the patient to take long expirations, to avoid waste of energy, and making the inspirations as short as possible. To this treatment he adds electric currents, which the patient uses at his own home. The latter is used only intermittently, but the fined mental principle of the treatment is the long the fundamental principle of the treatment is the long expirations and short inspirations, which require some practice and patience in those suffering from the disease. From the description given of these cases the results appear to be excellent. HYPERHYDROSIS.

Freund brought forward a young man who had come into hospital complaining of a severe form of hyper-hydrosis manum of the hand, which was success-fully treated by means of the Röntgen rays. This patient had both hands greatly enlarged and several of the fingers deformed. From the symmetry of the contractions at the phalangeal articulations, he concluded tractions at the phalangeal articulations, he concluded the deformity was congenital. Both of the little fingers were fixed at an angle of 120°, which could not be moved actively or passively. Extension could not be relieved by operation on the interphalangeal joints and dividing of the palmar aponeurosis. By closer examination the extension of the fingers were held by bands on both sides of the joint, which appear to have existed from childhood. The mother had also one hand with a little finger in a similar position, which favours the opinion of heredity. Schlesinger said he had seen several families suffering from the same contractions in the little fingers, but none of them had been so well marked as in this case.

TRAUMATIC NEUROSIS.

Benedikt presented a patient who in June, 1897, had a severe injury to the head, which left him suffering for a few days after from the symptoms of shock. About the middle of October slight hemiparesis of the right side, with all the appearance of traumatic neurosis commenced. The disease gradually green the research of the second property of the second part of the s worse up to 1900, when a series of epileptic fits commenced, with short periods of deafness at intervals, which appear to have been the epileptic equivalent. These attacks have continued for years, and have now brought on dementia, headache, uneasiness, and in-somnia. There can be little doubt on looking back over the history of this case that hæmorrhage had been caused by the injury to the head, which produced

pachymeningitis, and has now left in its train a form of chronic meningitis, with great thickening and induration.

RECURRING SARCOMA.

Schiller showed a lad, æt. 14, on whom he had operated several times for a recurring sarcoma on the upper part of the right tibia. The method he adopted was that of Mikulicz' conservative treatment. The tumour was incised a few centimetres around, and completely removed by opening the knee-joint, into which it had finally extended, involving the whole of the cartilage. The last operation involved the upper third of the tibia, which has caused the entire removal third of the tibia, which has caused the entire removal of that portion of the bone. This defect has been repaired by Hahn's osteoplastic operation, and the head of the fibula so placed that both condyles are brought into contact with it. With plaster and bindings the whole was retained in position till the healing was complete. Again, it was observed that the sarcomatous process had reappeared. Röntgen therapy was next applied, and Holzknecht's homogeneous rays applied, with a happy result. The historical examination revealed large spindle-should contact the sarcomatous processed that the sarcomatous processes the sarcomatous proc logical examination revealed large spindle-shaped sarcoma cells with the giant cells.

# LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

THE CENTRAL MIDWIVES BOARD AND SEPSIS RE VAGINAL EXAMINATIONS IN MIDWIFERY DURING LABOUR.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-Now that the new order in the medical profession-Midwives-has been established by law, and come to stay with us, everything ought to be done in the way of preliminary education, and the instruction, before going in for actual "training," should before going in for actual "training," should be sound. Then, the "training" after joining ought to be as thorough as possible in the use of catheter and speculum; the making of tampons or plugs; the names and uses of instruments—the various appliances that the medical man or woman may require, when perhaps there is no help at hand, but the midwife. I go so far as to say the well-trained midwife ought to be able to give chloroform, and to use the hypodermic syringe, and the different medicaments which may be required to be administered through it.

I deplore the three months' course.

What can be learned so as to be retained and utilised in that time? And then if the student be rushed through her 20 cases, and has no time for quiet study and thinking over her case, what will she be able to do when in practice? And if she do not get into practice (supposing she has gained her certificate) all will by degrees be slipping from her, till she feels unfit for her work when called

to fill a post.

The land is flooded with midwives. Can berths be found for all? And will the three months' cramming, or the rush through 20 cases avail her much in times of need? Will she not always have to be sending for

the doctor?

Why the subdivision into midwives and "monthly nurses?" I maintain that every "monthly nurse" should be a well-trained midwife, and not in any way a lower or inferior grade; indeed, she should be on a par with the best trained and accomplished midwife, since she is entrusted with the care of the young mother and of the new infant life.

I am, Sir yours truly,
G. DE G. GRIFFITH.

London.

MEDICAL ATTENDANCE IN HOTELS.

To the Editor of The Medical Press and Circular.

SIR,—With the growth of large hotels a certain number of new abuses have sprung up. One of these, comparatively rare, I hope, in England, is the association with the management of a special doctor, who is, so to say, foisted upon the visitors when they require medical attendance, and whose charges are often much higher than those generally current in the

locality. One of my own patients, a lady of small means, was most unfairly victimised a few days ago at a Swiss mountain resort, which I think better not to specify. Suffering from a slight sore throat, she was compelled to call in the hotel doctor, who prescribed a simple gargle, and called subsequently three times, when all symptoms had disappeared, to see how things were going on. In due course a bill of 200 francs, at the rate of £2 a visit, was sent in and paid, the lady not liking to make a fuss, although she was quite aware of the fact that the doctor who attended was a shareholder in the hotel and in league with the management, and that she could have had the services of the outside practitioner for 10 francs a visit. This, matter, I think, will interest many of your readers, and I trust you will find room for my complaint in your valuable columns.

I am, Sir, yours truly, AN ENGLISH DOCTOR ABROAD.

THE NEWSPAPER PRESS AND QUACKERY. To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—At an inquest in a neighbouring county during last year, the facts discussed in the correspondence now going on in your pages under the above heading

were forcibly exemplified. A child had died without medical attendance until in a moribund condition. The autopsy revealed double pneumonia as the cause of death. The parents, questioned as to the reasons. why they had not called in a doctor, stated that they had placed reliance upon an "infallible cough and lung cure" advertised in the local papers, and had continuously dosed the child with it from first to last. The coroner made some strong remarks about the folly of the parents, but did not suggest any inquiry into the composition of the nostrum, and a verdict of "death from natural causes" was returned. The name of the quack medicine was, of course, given by the parents, and frequently mentioned in the course of the inquiry. It was, however, entirely suppressed of the inquiry. It was, nowever, entirely suppressed in the reports of the case in every one of the local papers. Every one of these papers had contained, and still publishes regularly a puff of the infallible lung "cure." This is printed in the form of an editorial paragraph, and, being varied from week to week, serves, no doubt, to lead simple readers to believe that the medicine is really recommended by the newsnapers. The quack medicine trade is justly stigmatised by one of your correspondents as not only fraudulent, but cruel and deadly; and what can be said of newspaper proprietors whose chief profits are derived from this traffic, with the character of which they must be fully acquainted?

I am. Sir, yours truly,

A SURREY DOCTOR.

Near Reigate, March 12th, 1909.

OXYGEN IN SPORT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I am not confusing any point at issue, as Dr. Oscar Jennings says. Dr. Jennings wrote a letter to your journal which must have been based on some paragraph in the daily Press and therein charged me with publishing observations on the effect of oxygen on athletes, unsupported by any exact experiments, and at the same time claimed the priority of having made exact observations on the effect of oxygen on athletes. Dr. Jennings had no justification for making such an attack upon me. If he had sent a copy of his paper to me, it would have received my attention, and I should have acknowledged with pleasure the priority of any work that Dr. Jennings had done. Dr. Jennings' paper had not received notice in any of the standard books of reference which I have consulted, such as the "Handbuch der Sauerstafftherapie," edited by Michaelis, to which the leading German authorities, such as Loewy, Zuntry, and v. Schrötter have consuch as Loewy, Zuntry, and v. Schrötter have con-tributed, and was unknown to English physiologists. If Dr. Jennings had any conception of the enormous output of medical papers in Europe, mostly rubbish, and few of sterling worth, he would recognise the fact which all scientific men know that every new point must be discovered more or less a dozen times over indifferent countries, and that discussions on priority are not worth the paper they are written on, and he would not make an unwarrantable attack on me for not having discovered and published to the world the fact that he had written a paper on "Oxygen in Sport" in a weekly Parisian medical paper. The fact that oxygen helped an athlete to run, and especially when not in perfect training, was found to be the case by W. G. George twenty-five years ago, so there is no priority to be claimed in that.

Now as to the physiological explanation of this fact. Dr. Oscar Jennings claims the priority of having discovered that oxygen inhalation restores the blood pressure when lowered by forced exercise, and bases his claim on sphygmographic tracings. I am most willing to give him the priority he claims, but I re-assert that the sphygmograph is not an instrument by which blood-pressure can be measured; that it is difficult to apply it twice without modifying the form of the tracings obtained, especially by the old method of band-fixation, and that I myself have by this means hitherto been unable to obtain trustworthy evidence as

to the effect of oxygen.

Next Dr. Jennings says: "I demonstrated what he (Leonard Hill) has since ascertained, that oxygen in restoring wind did so by restoring the adequacy of the lung." But this is the very thing which I have not ascertained. The inhalation of oxygen after forced exercise has no effect on the breathing volume or the breathing frequency, as is shown by the figures by Mr. Martin Flack and published in the Journal of Physiology. The carbonic acid produced in the body regulates the breathing frequency and the volume. Oxygen acts on the heart, and restores the blood pressure, and lowers the pulse rate, and increases the neuro-muscular power of the man, it does not act in restoring wind by restoring the adequacy of the lung.

restoring wind by restoring the adequacy of the lung. Lastly, Sir, I stated that "I had ascertained that oxygen and exercise can be used as a valuable method of treatment;" this was in answer to your criticisms, which seemed to imply that the experiments of Mr. Martin Flack and myself were simply directed towards doping in sport. I never claimed to have discovered this, as Dr. lennings says, for I know too well that no discovery is ever made by one man, but that each worker adds but a little brick, sometimes, if he is lucky, a finishing one, to the buildings of Science. When Dr. Jennings claims the priority of this "invention," I am only glad that he should take it, and leave me to work out, as I am now doing, the exact extent to which oxygen inhalation influences the metabolism of the "working" man.

I am, Sir, yours truly,

LEONARD HILL.

Loughton, March 14th, 1909.

# SPECIAL ARTICLES.

LUNACY IN IRELAND. (a)

The Report of the Inspectors of Lunatics for Ireland for the year 1907 shows that the number of lunatics under care is still increasing. There was, in fact, a total increase of 164 during the year, the corresponding increase for the previous year having been 189. In last year's report it was pointed out that, with one exception, viz., 1893, when the increase amounted to 152, the increase during 1906 was less than that which took place during any of the previous 21 years. The increase in 1907, although slightly greater than that which took place in 1893, was 25 less than the increase which occurred in 1906. Further, the increase in 1907 was 295 less than the average increase for the preceding ten years, which was 459. When we study a long period of years, the increase is very striking. In 1880 the total number of lunatics under care in Ireland was 12,982; in 1907 it was 23,718. During the same period the population of the country has been steadily talling, and therefore the ratio of insane to sane inhabitants has apparently more than doubled in less

than thirty years. The actual figures are: in 1880 a proportion of 250 lunatics under care to 100,000 of the population, and in 1907 a proportion of 542. Of course, these figures may give an exaggerated notion of the amount of insanity in the country, for there is no doubt that there are much fewer insane not under care now than in 1880. We regret to note that, of the total number, there are still 3,053 in workhouses.

The inspectors remark that the connection between

insanity and tuberculous disease has been long recognised, and the prevalence of phthisis amongst the insane, whether confined in asylums or not, point to the importance of the subject in dealing with insanity. During the year 1907 the number of deaths in Irish District Asylums ascribed to phthisis was 400, giving a proportion amounting to 26.9 per cent. of the total deaths from all causes. Amongst the general population of Ireland in 1906, 12 per cent. of the total deaths were returned as due to this cause-being less than half the percentage amongst the insane in District Asylums. Attention is drawn to the measures adopted at Mullingar, Clonmel, and some other asylums to provide segregation wards for tuberculous patients, where fresh air treatment can be applied. Very few deaths occurred from general paralysis. Formerly this disease was almost unknown in Ireland, and even yet, with the exception of Belfast and Dublin, it is more rarely met with than in any other country in Europec.g., the proportion of deaths from general paralysis was 3.7 per cent. of the total deaths occurring in District Asylums in Ireland during 1906, whereas in the English asylums during that year it was 16.8 per cent. Attention is drawn to the great need for pathological study bearing on insanity in Ireland. In only 252 cases out of 1,486 deaths, was the cause of death verified by autopsy. Seven deaths by suicide occurred. In several asylums there were more or less serious outbreaks of typhoid fever. Thus, in Cork, there were 49 cases, in Ballinasloe 13, in Mullingar 7, in Ormagh 8, with no less than 4 deaths. The general death-rate varied much in different asylums, the lowest rate being in Waterford (4.2 per cent. of the average number resident), and the highest in Sligo (11.7 per cent).

The inspectors pay a well-deserved tribute to the memory of Dr. Conolly Norman.

# REVIEWS OF BOOKS.

THE EDINBURGH ATLAS OF OBSTETRICS. (a) THE third section of this Atlas has now been issued, and contains a most interesting collection of photographs. The first two of these show respectively the mamma of a multipara" and "the abdomen of a gravid multipara." The next two show certain diameters of the fœtal head. The next two show the positions of the head in a vertex presentation. In them the head is shown at the pelvic outlet, whereas, to show the position, it should be at the pelvic brim. Further, even if the authors desire to show the head at the outlet, flexion should be more marked. The next three photographs show the birth of the head. They are taken from life, and are good. The next photograph is blurred, and might as well have been omitted. next two photographs show the third stage of labour. The next four photographs are anatomical, and show placentæ and puerperal uteri. In one, Fig. 64, the condition of the uterus is pathological, and this should have been stated in the text. The next two photographs show feetal heads—some unmoulded and some de-formed. The next half-dozen photographs show the forceps and its application. They are uniformly good, but it was a mistake to show the assistants and operator with ungloved hands and unprotected arms. and he last photograph of the set shows a patient in Walcher's position.

<sup>(4) &</sup>quot;Lunacy in Ireland." The Fifty-Seventh Report (with Appendices) of the Inspectors of Lunatics (Ireland), for the year ending December 3|st. 1907. Dublin: H.M. Stationery Offices (Cd. 4302).

<sup>(</sup>a) "The Edinburgh Stereoscopic Atlas of Obstetrics." Edited by G. F. Barbour Simpson, M.D., F. R.C.P.E., F.R.C.S.E., F.R.S.E., Senior Assistant to the Professor of Midwifery in the University of Edinburgh, and Edward Burnet, B. A., M.B., B.Ch. With a preface by Rir Halliday Croom, M.D., F.R.C.P.E., F.R.C.S.E., Professor of Midwifery in the University of Edinburgh. In four Sections, each containing 25 subjects, with descriptive text. Section III. London: The Carton Publishing Company. 1908.

We congratulate the authors on these photographs, and the only adverse criticism we have to make on them is that they are too many different subjects mixed up together, only one of which can be regarded as finished-namely, the subject of forceps' application. One section alone now remains to complete the Atlas, and how the authors expect to crowd the remainder of obstetrics into it we do not know. Amongst the obstetric diagnosis, the mechanism of labour, all obstetric operations except the application of the forceps, and all pathological conditions except contracted pelvis. In other words, so far the authors have only touched on the fringe of their subject, and if they want the work to be an Atlas of Obstetrics, they must expand at least fourfold. We trust that the well-deserved success of these initial sections will be such as to justify the publishers in continuing their

## DISEASES OF THE NOSE, THROAT, AND EAR. (a)

In writing this volume Professor Ballenger has taken infinite pains to acquire the opinion of many of the most eminent specialists throughout the world in these three affiliated regions of surgery. Consequently, his book bears the stamp of authority which is enjoyed

by very few text-books on these subjects.

The author has divided his work into three parts. Part I. deals with nasal diseases. In this section Professor Ballenger lays great stress on the importance of correcting all deviations of the nasal septum, which he considers the fons et origo of many of the pathological conditions which affect the nasal chambers and their accessory sinuses. The method most strongly advocated for correcting these deformities is Killian's sub-mucous resection of the septum, whereby the proper ventilation and drainage of the nasal cavities are assured. In Part II., which deals with the pharynx and fauces, the importance of providing for ventilation and drainage is forcibly emphasised by the fact that many of the diseases of these parts are secondary to diseases of the nose. As regards the treatment of hyper-trephied tonsils and adenoids, we are entirely in accord with Professor Ballenger in condemning chloroform anæsthesia in cases of operation for their removal. Moreover, the author's method of extirpating the tonsil with its capsule intact is one which must appeal to all who have had the experience of recurrence which but too frequently follows their partial removal by other means

Part III. deals in a very admirable and thorough manner with diphtheria, tracheotomy, and intubation. A very concise and explicit account is given of the use of the bronchoscope and œsophagoscope in the diagnosis and treatment of diseases and of foreign bodies

in the air passages and gullet.

The chapter on neoplasms of the larynx and their surgical treatment is exhaustively and well illustrated. We have nothing but praise for Part IV., which so clearly treats of the anatomy, physiology, and pathological conditions which are found in the ear. The various tests usually applied in diseased conditions of the organ of hearing are fully described. The chapters on suppurative otitis media and mastoiditis are particularly extensive. The descriptions of the mastoid operations are exceptionally full and thoroughly illustrated by a series of well-executed drawings. complications of middle ear suppuration as brain abscess, thrombosis of the lateral sinus, and facial paralysis, receive appropriate attention.

The book closes with a short chapter on deaf mutism. the ætiological factors of which are briefly discussed.

We can heartily recommend Professor Ballenger's work to both specialist and general practitioner, with the fullest assurance that it will be duly appreciated by all who have the good fortune to read it. From beginning to end the volume is clear, explicit and concise, and throughout the text is beautifully illustrated by some 500 original drawings and photographs.

# LITERARY NOTES.

MESSES. BALE, SONS AND DANIELSSON have sent us a copy of a new chart, which has been designed by the superintendent of a large sanatorium in order that the particulars of each case may be kept uniformly from day to day for three months, and be available at any moment for reference. They can be obtained singly or bound in books of 25.

Mr. Wells is always up-to-date in his literary methods, and his new novel, "Tono-Bungay," describes with remarkable power the methods adopted in advertising a worthless patent medicine, and how an enormous fortune was made out of it. The book is well worth perusing by all who are interested in the suppression of one of the greatest evils of modern times. It should appeal specially to all members of the medical profession, to whose earnest attention we cordially recommend this "novel with a purpose."

MESSRS. WILLIAM HODGE AND Co., Edinburgh and Glasgow, will publish shortly a small book by the Rev. Father Power, S.J., Edinburgh, entitled, "The Alcohol Case: The Summing-up. A Medical, Legal, and Historical Sketch." In this book the author's contention is that in some cases alcohol is deserving, like other poisonous or semi-poisonous drugs administered by skilled hands, of the epithet of "life-preserving," but that of its own nature it must be classified among the death-dealing agents that make more or less successful war on human life. Father Power belongs to the London Society for the Study of Inebriety, and has studied his subject not only in the vast literature bearing on alcohol, but in the vaster host of victims of alcoholic disease.

## NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publication of our last monthly list:—

BAILLIERE, TINDALL AND COX (London).

The "Nauheim" Treatment of Diseases of the Heart and Circula-tion. By Leslie Thorne Thorne, M.D., B.S.Durh., M.R.C.S. Eng., L.R.C.P.Lond. Third Edition. Pp. 82. Price 3s. 6d.

net, Third Report of the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum. By Andrew Balfour, M.D., B.Sc., etc., etc., Illustrated. Published for the Department of Education, Sudan Government, Khartoum. Pp. 477.

M.D., B.Sc., etc., Etc.,

Initatiations and plates. Price 7s. 6d.

Price 12s. 6d. net.

Cassell and Co., Ltd. (London).

A Manual of Medical Treatment or Clinical Therapeutics.

New Edition. By J. Burney Yeo, M.D., F.R.C.P., Raymond Crawford, M.A., M.D., F.R.C.S., and E. Farquhar Buzzard, M.A., M.D., F.R.C.S. 2 vols. Pp. 1,631. Price 21s. net.

Churchill, J. and A. (London).

Chavasse's Advice to a Wife. Revised by G. Drummond Robinson, M.D., B.S.Lond., F.R.C.P. Fifteenth Edition. Pp. 360. Price 2s. 6d. net.

Henri Frowde and Hodder and Stoughton (London)

Oxford Medical Publications. Infant Feeding. A Practical Guide to the Artificial Feeding of Infants. By J. S. Fowler, M.D., F.R.C.P.Edin. Pp. 230. Price 5s. net.

A System of Operative Surgery. By various authors. Edited by F. F. Burghard, M.S.Lond., F.R.C.S.Eng. In four vols. Vol. I. Pp. 751. Price 36s. net per vol.

Manual of Operative Surgery. By H. J. Waring, M.D., M.B., B.Sc., F.R.C.S.

Price 12s. 6d. net.

H. K. Lewis (London).

H. K. LEWIS (London).

The Causation of Sex. A New Theory of Sex Based on Clinical

<sup>(</sup>a) "Diseases of the Nose, Throat, and Ear." By William Lincoln Ballenger, M.D., Professor of Otology, &c., College of Physicians and Surgeons, University of Illinois, &c. Nine hundred pages, 471 engravings, and 16 plates. London: Henry Kimpton: Glasgow: Alexander Stenhouse. 1908.

Materials. By E. Rumley Dawson, L.R.C.P.Lond., M.R.C.S. Eng. Pp. 196. Price 6s. net.
The Operations of Aural Surgery. Together with Those for the Relief of the Intracranial Complications of Suppurative Otitis Media. By C. Ernest West, F.R.C.S., and Sydney R. Scott, M.S., F.R.C.S. Pp. 201. Price 7s. 6d. net.

Longmans, Green and Co. (London).

An Introduction to the Science of Radio-Activity. By Charles W. Raffety. Pp. 208. Price 4s. 6d. net.

The General Characters of the Proteins. By S. B. Schryver, Ph.D., D.Sc. Pp. 86. Price 2s. 6d. net.

The Human Species. By Ludwig Hoff. Authorised English Edition. Illustrated. Pp. 457. Price 10s. 6d. net.

MACMILLAN AND CO., LTD. (London)
On the Poison of Venomous Snakes and the Methods of Preventing Death from their Bite. Reprinted Papers. Ry the late Sir Joseph Fayrer, Bart., K.C.S.I., M.D., F.R.C.P., F.R.S., Sir Lauder Brunton, Bart., LL.D., M.D., F.R.C.P., F.R.S., and Major Leonard Rogers, I.M.S., M.S., F.R.C.P., F.R.S., and Major Leonard Rogers, I.M.S., M.S., F.R.C.P., F.R.S., Sand Major Leonard Rogers, I.M.S., N.S., F.R.C.P., F.R.S., Sand Major Leonard Rogers, I.M.S., M.S., F.R.C.P., F.R.S., Sir Lauder Brunton, Bart., LL.D., M.D., F.R.C.P., F.R.C.S. Pp. 174. Price 2s. 6d. net.

Tono-Burgay. By H. G. Wells. Pp. 493. Price 6s.

MACLEHOSE, JAMES, AND SONS (Glasgow).

Manual of Diseases of the Ear, including those of the Nose and Throat in Relation to the Ear. By Thomas Rarr, M.D., and J. Stoddart Barr, M.B., Ch.B. Fourth Edition, entirely revised and largely rewritten. Pp. 477. Price 14s. net.

"THE MEDICAL REVIEW" (London).

"An Analytical Index of Vols. I.-X. of the Medical Review and Digest of the Facts Important to the Practitioner in the Medical Periodicals of the World, 1838-1907." Price 7s. 6d. net.

JAMES NISBET AND CO., LIMITED (London).

"An Analytical Index of Vols. I.-X. of the Medical Review and Digest of the Facts Important to the Practitioner in the Medical Proteitioners. Part II., The Local Directory of Medical Practitioners. Part II., The Local Director

JOHN WRIGHT AND SONS, LTD. (Bristol).

Health, Morals, and Longevity. By George Gresswell, M.A., L.R.C.P., etc., and Albert Gresswell, M.A., M.D., etc., etc., Pp. 229. Price 5s. net.

# **NEW PREPARATIONS.**

MESSRS. PARKE, DAVIS AND CO.'S NEW VACCINES.

This well-known firm has sent for our inspection three new vaccines issued by the Department for Therapeutic Inoculation at St. Mary's Hospital, W., under the direction of Sir A. E. Wright, M.D. Two of these vaccines are provided for the treatment of varying forms of acne. The mixed vaccine for acne contains are million staphylogogic and Smillion. varying forms of acne. The mixed vaccine for acne contains 200 million staphylococci and 8 million acne bacilli per c.c., and is applicable for cases in which the staphylococcus is playing the more important part, as those in which the lesions assume a subfuruncular form. The Acne Bacillus Vaccine contains acne bacilli alone (8 million per c.c.) and is applicable for cases in which the staphylococcus, if present is but a subordinate factor, as in non-pustular present, is but a subordinate factor, as in non-pustular forms with comedones as a principal feature. The needs of suppurative forms of acne are met by the Staphylococcus Vaccine (in dilutions of 100, 200 and 500 million per c.c.), which has been supplied for some time past. The third new vaccine—Neoformans Vaccine—is issued for use as an auxiliary to other treatment of cancer, of which it is found to relieve pain by suppressing local inflammation, whilst it also appears to prolong life by diminishing the cachexia. It is not claimed to be a curative agent. It is prepared from the micrococcus neoformans of Doyen, of which it contains 30 million per c.c.

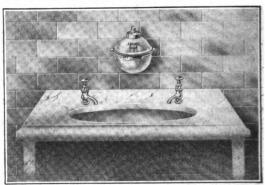
BURROUGHS WELLCOME'S ERGOTOXINE.

WE have been favoured with specimens of ergotoxine by Messrs. Burroughs Wellcome. They controvert the statements that the alkaloid ergotoxine is not yet obtainable in the pure state, and that its action in causing paralysis of the motor fibres in the

sympathetic is due to the presence of some impurity. The deduction has been drawn that it is better to use a fresh and properly standardised liquid extract of ergot rather than ergotoxine, in all cases where it is desired to excite the uterus powerfully or to raise blood pressure. Further, the suggestion has been offered that cornutin should be adopted as a synonym for ergotoxine. The specimen of pure ergotoxine or ergotoxine. The specimen of pure ergotoxine phosphate submitted to us demonstrates that the first statement is misleading. The salt has the formula C35 H41 O6 N5, H3 PO4, H20, crystallises in needles, melting at 186—187° C., and from it the alkaloid ergotoxine can be regenerated in a state of chemical purity. The physiological action of ergotoxine was investigated by H. H. Dale, M.A., B.C. (Biochem. Journ. II., 240-299, 1907), and it was clearly shown that, while ergotinine is practically inactive, the familiar effects of ergot on the blood pressure and the uterus, and in the production of gangrene, are all produced by pure ergotoxine and its salts; in addition, they were found to produce the secondary paralytic effect on motor fibres of the sympathetic system which Dale had observed with many preparations, and which is characteristic of ergotoxine alone among pharma-ceutical principles of which the action has yet been examined. There is as little justification for the sug-gested identity with cornutin, which is the name given by Kobert in 1884 to an impure alkaloidal resin which he obtained from ergot, and which had, as its distinctive physiological characteristic, the property of producing convulsions. The suggestion that ergotoxine and cornutin are synonymous is, in fact, directly opposed to the conclusion of all those who are entitled to express an opinion on the subject.

A LIQUID SOAP DISPENSER.

We have had placed at our disposal a most ingenious contrivance for the dispensing of liquid soap. The object is to substitute a handy method of obtaining the necessary amount of soap for cleansing purposes in liquid instead of solid form. The saponaceous fluid is stored in a glass globe, and when the latter is tilted a few drops of liquid soap are ejected from the nozzle at the top, and washing is conducted in the usual manner. The economy and convenience of this plan are obvious, and a little consideration will show that there are obvious advantages in doing away with the old-fashioned cake of soap. A future may safely be predicted for the soap dispenser in hospital practice. It may stand upright upon the edge of the washing



basin or be fixed over the latter against the wall. When required in aseptic work it can be fitted with a contrivance worked with a foot lever whereby the soap is ejected without touching the apparatus with the hands. From personal experience we are inclined to agree with the claims of the proprietors of this clever little American invention that the plan is cleanly, sanitary, expeditious and economical. The dispenser is sold at the moderate wice of tee for and or call at the moderate wice of tee for and or call at the moderate wice of tee for and or call at the moderate wice of tee for and or call at the moderate wice of tee for and or call at the moderate wice of tee for and or call at the moderate wice of tee for and or call at the moderate with the hands. the moderate price of 10s. 6d., and an excellent liquid soap is supplied at a cost of 10s. 6d. per gallon, unscented, or 12s. 6d. scented. It is, of course, open to anyone to add any antiseptic or other drugs that may be considered advisable. The English agent is Mr. Charles Flint, 25 Victoria Street, Westminster, Charles Flint, London, S.W. 25

# OF RECENT MEDICAL LITERATURE, Summary ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

Tuberculosis of the Cæcum.—(Rogers, Surg., Gyn., and Obst., viii., 2.)—Tuberculosis affecting the cæcum occurs in two distinct and well-defined forms:—(1) Tuberculosis having its focus of infection in the mucous membrane and affecting usually the lower ileum and excum simultaneously. (2) The hypertrophic tuberculosis of the French, confined chiefly to the excum. The first variety occurs almost entirely secondary to an advanced tubercular lesion elsewhere in the body, usually secondary to pulmonary disease, having been excited by the sputum swallowed. Hypertrophic tuberculosis of the cæcum, unlike the ulcerative form, is usually a primary affection; the most probable conclusion is, that the infection is brought about by ingested food. The affection is limited nearly always to the cæcum alone, and extends along the colon. The origin of the disease is ordinarily in the submucous layer of the gut wall affecting the lymphatic structures in this situation; less commonly the process apparently begins in the sub-peritoneal structures. The process is exceedingly slow, and the foci of infection, which may be limited to one portion of the gut wall, or may be distributed more diffusely, act as a kind of irritant exciting an inflammatory reaction which constitutes the so-called sclerous evolution, through which the walls of the cæcum become enormously hypertrophied and thickened, and the cæcum presents the appearance of a real neoplasm. The cæcum externally is irregu-larly nodular in outline, and is intimately associated larly nodular in outline, and is intimately associated with the pericæcal gut, which has undergone a fibrous change, such as the fibro-lipomatous change round a tubercular kidney. The mesenteric glands in the ileocæcal angle are, as a rule, involved, and the appendix is usually affected secondarily, and may possess the same hypertrophic changes that occur in the cæcum. The diagnosis of a tubercular process in the cæcum is extremely difficult, and without a minute examination into every detail of the history of the case and physical findings an incorrect diagnosis will be made physical findings, an incorrect diagnosis will be made in the vast majority of cases previous to an abdominal section. Even when the growth has been removed, it is difficult in a number of cases, without an exploration of the tumour, to say whether one is dealing with tuberculosis or cancer. When dealing with a case owing to the lesion being in the right iliac fossa, there is a strong tendency to conclude that the appendix is at fault, but the general condition of the patient, and the long duration of symptoms with persistence of tumour, should point to either tuberculosis or cancer. In differentiating these, no single symptom, and hardly a group of symptoms, is characteristic of either, and all the evidence is only of limited value. The chief differences are the younger patient, great chronicity, tendency to extend in the length of the gut, and marked tendency to stenosis in tuberculosis, while blood and pus in the stools is strongly in favour of cancer. A tubercular lesion elsewhere is strongly suggestive F.

An Analysis of Eighty Consecutive Cases of Ectopic Gestation.—Frank (Amer. Journ. of Obs., lix. 2). This paper is based on the records of eighty unselected consecutive cases of ectopic gestation. Only one patient was below the age of twenty years. Divided into three periods of five years each, covering the ages from 20-35, each of the five years show an equal number of cases. In the entire series, only twelve patients had never been previously pregnant, and of these six had been married less than one year. Ten women had had no pregnancy for more than four Ten women had had no pregnancy for more than four years preceding their present illness (12.5 per cent.), while six (7.5 per cent.) acquired ectopic gestation in the first six months of marriage. From this it seems that sterility plays but a subsidiary part in ectopic gestation. Of the eighty cases, just half (40) were

overdue in their menstrual history. In the majority of the remainder the menstrual period had not been skipped. Spotting occurred at some time during the course of the illness in a large majority—72.5 per cent. Pain was complained of in almost every case. In 60 per cent. the pain was definitely located to the right or left iliac fossa, in the others the pain was felt over the entire abdomen. In only six cases was the pain on the opposite side to the gestation. It was generally described as knife-like or cramp-like. On admission, forty-six of the patients had a temperature from 98.6-100 degs. per rectum. In the others temperatures above 100 degs. were noted. No striking differences between the variety of ectopic encountered (rupture, abortion, hæmatocele) were shown, with the exception of infected hæmatoceles. A few actively bleeding patients, in collapse, had subnormal temperatures, but not sufficient to aid in diagnosis. The pulse rate is often accelerated by excitement, and con-sequently a source of error, but the quality and regularity are less likely to mislead, if attention is paid to the general appearance of the patient, the degree of pallor, the circulation in the extremities, and degree of pallor, the circulation in the extremities, and the amount of air-hunger, if present. Local signs.—
The uterus, with few exceptions, was somewhat increased in size and softened. In one case where lactation amenorrhoea was present, and in another the subject of chronic adnexal disease, the uterus was very small. In 80 per cent, of the patients a mass was palpable in one of the fornices or in Douglas' pouch. The mass was usually described as boggy and was regularly tender to pressure, and pulsation in the pouch. The mass was usually described as boggy and was regularly tender to pressure, and pulsation in the region was increased. The discovery of a mass in connection with a history suspicious of ectopic in almost every instance was sufficient to assure a correct diagnosis. The physical examination of the 80 cases showed as follows:—No physical signs, 7; mass present, 63; mass absent, 8; mass doubtful, 2. Morning vomiting and increase in the size of hearts was repeatedly noted. Fainting one or more times occurred in 32 per cent. of the cases, and was looked upon as a valuable symptom. Blood counts were not indicative of any particular condicounts were not indicative of any particular condi-tion. The great majority of cases demanding imme-diate operation according to the indications followed in the service, were ruptures of the tube. The only hæmatocele, opened at once after admission, was very large, and caused obstructive symptoms and great pain. large, and caused obstructive symptoms and great pain. The abdominal method was preferred in nearly all cases, five operations for other than well encapsuled hæmatoceles, were started per vaginam, and of these three required immediate abdominal section for hæmorrhage, uncontrollable from below. Even small hæmatoceles bulging downwards into the vagina are probably better treated by laparotomy, which requires a shorter stay in hospital than by the vaginal method. If the patient with hæmatocele shows signs of infection, the vaginal route is followed of necessity. There were three deaths in 80 cases. (1) Hæmatocele aspirated per vaginam, followed by peritonitis. Laparotomy and pan-hysterectomy five days later. Laparotomy and pan-hysterectomy five days later.

(2) The patient was curetted owing to wrong diagnosis. Laparotomy for collapse, which was extreme one hour after curettage, owing to internal bleeding.

(3) Patient admitted in profound collapse, immediate operation, active bleeding found continuing. The first death cannot be ascribed to the ectopic gestation nor the immediate operation. The second was due to wrong diagnosis and the masking of conditions by the anaesthetic. In the third case the nation was in extension and still bleeding. case the patient was in extremis, and still bleeding. Complications met at operation were very few. Only in nine cases were old inflammatory conditions met with, and none showed dense adhesions. Conclusions: No possible examination should be carried out and

cureftage not done till ectopic is absolutely excluded. If after two or three days the condition had not definitely improved, and no marked tendency to hæmatocele developed, laparotomy is indicated. Should severe attacks of pain, fainting, or collapse ensue during period of waiting, operate at once. In well-defined hæmatoceles vaginal section and drainage suffices, but convalescence is more prolonged than by laparotomy. If a patient when first seen is in a pre-carious condition, it is safer to err on the side of early operation than to wait.

The Best Methods of Promptly Terminating the First Stage of Labour, with Special Reference to Vaginal Cesarean Section.—Fry (Amer. Journ. of Obst., lix., 2.)—When prompt or rapid evacuation of the uterus is indicated, in the interests of mother or child, one can now choose between manual dilatation, and the indicate of the case multiple incision of the cervix, instrumental dilatation and vaginal Casarean section. The anatomic and physiologic conditions of the cervix furnish the key to the situation, and should be the guide for determining the method applicable to each particular case. As a rule, manual dilatation and multiple incisions are applicable only after obliteration of the canal, while instrumental dilatation and vaginal section are required when the cervix is intact. Multiple incisions are intended to overcome the resistance of the external os, therefore effacement of the cervical canal is a pre-requisite to its employment. Vaginal section is a surgical procedure that overcomes the complication by correct surgical principles. A powerful sphincter muscle that is unprepared by Nature for dilatation is cut, and the obstruction overcome with little danger of subsequent laceration. Instead of leaving lacerated author reported fifteen cases of eclampsia, with one maternal death, of which twelve were treated by vaginal Cæsarean section and delivery In his paper he reviews the teaching of recent books, and con-siders that the merits of vaginal section are not recognised when the indications exist for prompt evacuation of the uterus with an intact cervix, while the operation has been sufficiently tested to warrant confidence

Pathology and Treatment of Purulent Pleuritis. Billings (the Journ. Amer. Med. Assoc., January 23rd, 1909) discusses the pathology and treatment of puru-lent pleuritis. He dwells especially on two forms of treatment, that of continuous suction as advised by Dr Joseph Bryant, and the injection of formalin in glycerine, as recommended by Dr. John Murphy. In the case of infection by the pneumococcus, where the prognosis is comparatively favourable, the treatment by Bryant's method has certain advantages over the older treatment of resection of a rib and drainage. Not only is the exudate evacuated in this way, but the influence of the negative pressure, supplemented by the normal respiratory movement, is of great benefit in expanding the former atelectatic lung. By this method the average duration of the treatment is said to be the average duration of the treatment is said to be considerably shortened. In Murphy's method the pus is first evacuated by aspiration, and then from one to five ounces of a 2 per cent. solution of formalin in glycerine is injected into the pleural cavity. The treatment is repeated in ten days or a fortnight, if necessary. Dr. Billings reports seven cases treated in this way. Of these three died, but two were practically hopeless when treated. Of the four that recally hopeless when treated. Of the four that recovered, all, except a woman, æt. 30, were children. The average number of injections were two, and the length of time from the first injection to the discharge of the patient was from four to six weeks. All the cases were metapneumonic.

# **OBITUARY.**

DR. JOHN HENRY KEELING, OF SHEFFIELD. We regret to anounce the death of Dr. J. H. Keeling, which took place at his residence in Sheffield on the 13th inst., at the age of 77. He was born at Malta in 1831, and proceeded in due course to Edinburgh Uni-

versity, a medical career having been decided upon, and after studying there from 1848 to 1852 he received his degree of M.D.

On leaving Edinburgh he continued his studies in London, and spent some time also in Paris and Vienna, where he attended the practice of the most distinguished men in those Capitals. In 1869 he became a Fellow of the Royal College of Surgeons. In a reflow of the Royal College of Surgeons. In 1854 the war against Russia broke out, and Keeling went to the Crimea as surgeon in the Turkish Army, a service afterwards rewarded by his appointment as officer of the Order of the Medjidieh. As early as 1860—March 27th—he was appointed Lecturer on Medical Jurisprudence at the Sheffield Medical School, thus beginning an association with the teaching as well as the practice of medicine in Sheffield, which lasted for nearly 40 years. Four years later Dr. Keeling as the practice of medicine in Shemeld, which lasted for nearly 40 years. Four years later Dr. Keeling became Lecturer on Physiology. He resigned the Lectureship in Physiology, and was appointed, in conjunction with Dr. Aveling, to lecture on his special subject, "Midwifery and Diseases of Women." He continued to lecture on that subject for 32 years.

After his retirement from an active connection with

the Royal Hospital, he, at the request of his colleagues, the Royal Hospital, he, at the request of his colleagues, remained a member of the Clinical Committee, which regulates the teaching at both the Royal Infirmary and the Royal Hospital. The Jessop Hospital, the Public Hospital and Dispensary, now the Sheffield Royal Hospital, also enjoyed the benefit of Dr. Keeling's services. He was elected Surgeon of the Hospital in 1867, in place of Mr. J. F. Wright, resigned, and held the post for 25 years.

the post for 25 years.

# MEDICAL NEWS IN BRIEF.

Contract Practice at Manchester.

MR. GEORGE WILDE, President of the National Friendly Societies' Conference, which represents a membership of nearly five millions, made some interesting remarks on the controversy between the medical profession and the Friendly Societies, when seen in Manchester by a representative of the Manchester Evening Chronicle.

"This has been a burning subject for many years," he remarked. "It is quite true that some medical gentlemen are working at contract rates at a small sum. That is due to the doctors themselves. When societies or clubs have advertised for a medical officer by tender, or clubs have advertised for a medical officer by fender, they have generally, like other bodies, accepted the lowest tender. Hence the disparity in prices between one district and another. It is only fair, however, to say that in towns the members of a club or society generally live within a small radius, and in such cases the medical man is able to visit them much more speedily than in country places.

"It would be a good thing, both for friendly socie

ties and the medical profession, if joint meetings could be brought about in various parts of the country to deal with local circumstances and to arrange a rate below which clubs and societies should not ask a doctor to work; but the time has gone by for any move on the part of the medical men to lay down the principle of asking clubs or societies to exclude any of their members who may be earning more than a certain income, or who may be paying above a certain rental, from

medical assistance.

"Many people who have joined friendly societies may be successful in business in later years, but they remain consistent and active workers of the society which gave them their first impetus in social life. In many cases, although they pay their medical benefit contributions, they do not call upon the club doctor. I quite admit that there are exceptional cases, where man who can afford to pay a private practitioner will

claim his full benefit.

"Doctors in many parts have absolutely refused to accept contract rates for women. This has been a great blow to the establishment of women's lodges, and it has convinced the leaders of the friend'y societies that the aim of the medical profession is to do away with contract rates of payment altogether. The knowledge of this fact is causing many friendly and trade socie-

ties to join in the establishment of medical aid associations, and the medical profession will be wise in making up its mind to work in conjunction with these bodies, rather than set its back with a determination to dictate its own terms, either by way of contract, or its abolition."

## Royal College of Surgeons of England.

At the meeting of the Council of the College, held on Thursday last, Mr. Henry Morris, F.R.C.S., Presi-

dent, in the chair.

Mr. Frederick J. F. Barrington, M.B., B.S.Lond., M.R.C.S., House Surgeon to University College Hospital, was admitted a Fellow of the College, and Dr. Claude Edward Freer Fortin, of McGill University, Montreal, and Middlesex Hospital, was admitted a member. Diplomas of the College Licence to practice Dental Surgery were issued to Mr. Reginald Henry Christmas Baker, of the Middlesex and National Dental Hospitals, and to Mr. Henry Vincent Gibbons, of Guy's Hospital Dental School.

A report from the Committee appointed to prepare a new by-law relating to the admission of women to examination for the diplomas of the College was received. The report was considered and the proposed new by-law will come before the Council at their next meeting for further consideration and final approval.

The attention of the Council was called to the petition of the British Medical Association for the grant of a Charter of Incorporation. A committee was appointed to consider the terms of the proposed charter and its bearing upon the position of the College and the rights of its Fellows and members.

Mr. Henry Morris was re-elected the representative of the College in the General Medical Council for the next five years, and Mr. F. Richardson Cross was appointed the next Bradshaw Lecturer for the ensuing Collegiate year.

## Typhus Epidemic in Madrid.

THE authorities at Madrid are seriously alarmed by the typhus epidemic, and are attempting to exercise a censorship over all newspaper telegrams, which necessitates forwarding despatches by an indirect method.

The Mayor of Madrid is the latest victim of the disease, and his condition is serious. Several other pron.ir.ent municipal officials are suffering, and the hospitals are crowded, there being nearly 300 cases in the San Juan de Dios hospital alone.

Between 40 and 50 deaths from typhus occurred during February.

# King's Co lege Hospital.

THE Committee for the removal of King's College Hospital to South London have received a cheque for £2,500 from the trustees of the late Mr. Zunz, this being a second instalment of a grant of £10,000 promised to the fund on the condition that a ward in the new hospital containing not fewer than 20 beds is to be called the "Annie Zunz Ward" in perpetuity.

## A Novel Method for Building Hospitals.

THE Copenhagen correspondent of the Standard newspaper writes that for the last five years the postal December to bear an extra stamp, value about one farthing. The income of this so-called Christmas stamp was intended by the originator of the idea—a clerk at the General Post Office-to found a hospital for consumptive children. Last year saw the amount brought to the sum required for the building, and the foundation-stone is to be laid this week. It is expected that the future sale of this stamp will be sufficient as the population and business increases not only to defray the current expenses attending the up-keep of the hospital, but also to enable the committee to build more hospitals, which are sadly wanted in Sweden.

## " Spiritual Healing."

AT a meeting of the Church and Medical Union, held last week at the Church House, a paper was read by Dr. L. W. Bathurst, in which he discussed the effect which the movement is likely to have on the rela-

tionship between the Church and the medical faculty. He took the line that the profession is very far from being convinced that there is need for any such movement, and, in the second place, held strongly to the view that it cannot be expected to take any share in their attention to administering comfort and consola-tion, and encouraging cheerfulness, prayer, faith, hope, fortitude, and resignation, in accordance with circumstances, so long, says Dr. Bathurst, will the medical profession welcome their co-operation. as regards those who are credited with special gifts in the matter of healing, he declared that if medical men were to submit their patients to them, they would be running altogether counter to the General Medical Council in its efforts to put down unqualified practice. Dr. Bathurst sums up what he conceives to be the opinions of the medical profession on this subject under the following headings:

(1) If the Church wishes the co-operation of the medical profession, she must propound her views and intentions, and say exactly in what manner her proposals are to be carried out.

(2) The medical profession does not recognise the pecial gifts of healing claimed by unqualified and irresponsible persons—claims which, if admitted or sanctioned, could only serve to open wider the door to quackery.

(3) The medical profession cannot, from a practical point of view, be regarded, as has been suggested, as

the handmaiden of the Church.

## Vital Statistics.

THE deaths registered last week in the eighty great towns of the United Kingdom corresponded to an annual rate of 21.3 per 1,000 of their aggregate population. In the preceding three weeks the rates had been 17.5, 18.1, and 19.1.

Measured by last week's mortality, the highest

annual death-rates per 1,000 living were:—From all causes, 28.0 in Rhondda, 28.7 in Stockport, 29.1 in Rochdale, 29.5 in Hanley, 29.9 in Wigan and in Bury, 35.6 in St. Helens, and 26.6 in Dublin. The deathrate from measles was 3.5 in Sheffield, 3.9 in Birmingham, 4.4 in Smethwick, 5.9 in West Hartlepool, 7.2 in Warrington, 7.3 in Aston Manor, and 8.8 in St. Helens; from scarlet fever, 1.6 in St. Helens; from diphtheria, 1.0 in Stockport and 1.3 in Kings Norton; from whooping cough, 1.1 in Suggestion Norton; from whooping-cough, 1.1 in Swansea, 1,2 in Aston Manor, 1.3 in South Shields, 1.7 in Wigan, and 2.7 in St. Helens; and from diarrhoea, 2.0 in Great Yarmouth. No death from small-pox was registered in any part of the United Kingdom.

Navy Medical Service.

In the course of his memorandum on the state of

tue Navy, Mr. R. McKenna says:

The recruiting of the Naval Medical Service has for some time been a matter of anxiety to successive Boards of Admiralty. I have now appointed a Committee to inquire into the Naval Medical Service, composed as follows:

'Admiral Sir John Durnford, K.C.B., D.S.O. (Chairman).

Inspector-General James Porter, C.B., M.D., M.A.

(Medical Director-General).

"Surgeon-General Sir Affred Keogh, K.C.B., M.D.
"Mr. J. H. Brooks, Principal Clerk.
"Sir William W. Cheyne, Bart., C.B.
"Deputy-Inspector-General William H. Nodman,

"Mr. G. L. Cheatle, C.B., F.R.C.S.

"Mr. J. S. Barnes, Admiralty, Secretary.
"We hope, with the able assistance of these gentlemen, that we shall devise some means of putting the Naval Medical Service upon a more satisfactory footing."

## Trinity College, Dublin.

During Hilary Term, 1909, the following candidates Possed the Final Examination in Medicine, Part II.:— Douglas M. Moffat and Albert J. Stals (passed on high marks), John D. Kernan, Henry R. Kenny, Frederick R. Sayers, Charles G. S. Baronsfeather, Denis J. Stokes, Charles B. Jones.

# **NOTICES TO** CORRESPONDENTS, &c.

CORRESPONDENTS requiring a reply in this column are particularly, requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Beader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January lat and July 1st respectively. Terms per annum, 21s.; post free at home cr abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12. Messrs. Dawson and Sons are our special agents for Canada.

ORIGINAL ARTICLES on Extrems intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

S. C. T.—The power to close schools in epidemic disease does not rest with the school Medical Officer, but with the Medical Officer of Health. When the former officer is subordinate to the latter, there is, of course, no difficulty, but when the offices are distinct and independent of each other, the school officer must work through his colleague. The wisdom of closing schools is frequently questioned, on the ground that the children who would have met in the school then met in the alleys and streets, and infect each other just the same. Our own view is that in epidemic times the precaution is one that should be taken, and in the case of messles in infant departments, it is almost the only measure that can be used.

J. J. S. (Bromsgraye).—It does not follow that because a patient died while under the influence of an anæsthetic that death resulted from the administration. Each case must obviously be judged upon its merits. A further fallacy connected with this subject is the "delayed" deaths which follow within a few days in the case of chloroform, and it may be one or two weeks or more from lung complications in t

with angesthetics.

CLINICIAN (Southgate).—At times severe nervous complications follow measles. In the acute stages those are usually of a texic nature. In rare instances mania and melancholia have been known to follow the malady, but in these cases there is nearly always a history of neurosis.

DR. WARRINGTON.—Your paper is marked for insertion in our next week's issue.

MR. J. E. R.—We are making the necessary inquiries, the results of which will be dealt with in an early number.

# Meetings of the Societies, Tectures, &c. WEDNESDAY, MARCH 17TH.

WEDNESDAY, MARCH 17TH.

ROYAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inu Fields, W.O.).—5 p.m.: Prof. C. W. Rowntree: X-Ray Carcinoms, and an Experimental Inquiry into Certain Conditions preceding its fonset. (Hunterian Lecture.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Control of the Control of

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. B. P. Brooksi.

THURSDAY, MARCH 18TH.

ROTAL SOCIETY OF MEDICINE (DERMATOLOGICAL SECTION) (2C Hanover Square, W.).—5 p.m.: Exhibition of Cases.

CHILD STUDY SOCIETY LONDON (Parkes Museum, Margaret Street, W.).—8 p.m.: Mr. T. H. Hewitt: Handieraft as a Factor in Mental Evolution.

CHILD STIDY SOCIETY LONDON (PERSON MUSEUM, MAIGNAND MY).—B p.m.; Mr. T. H. Hewitt: Handieraft as a Factor in Mental Evolution.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mail East).—
5 p.m.; Dr. A. E. Russell: Some Disorders of the Cerebral Circulation and their Clinical Manifestations. (Goulstonian Cartinology)

Lectures.)
NORTH-EAST LONDON POST-GRADUATE COLLEGE (Princ NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. A. E. Glies). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture: Dr. A. E. Glies: The Scope of Gynæcological Treatment without Operation.

St. John's Hobstital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture: On the Treatment of Skin Diseases.

FRIDAT. MARCH 19TH.

of Skin Disease.

FRIDAT, MARCH 19TH.

ROTAL SOCIETY OF MEDICINE (ELECTRO-THERAPEUTICAL SECTION)
(20 Hanover Square, W.)—8.30 p.m.: Paper: Dr. H. Lewis
Jones: Treatment of Nævus.

ROTAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Fields,
W.C.).—5 p.m.: Prof. S. G. Shattook: Certain Matters in conLexion with Internal Secretions. (Hunterian Lecture.)

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road,
W.C.).—3.45 p.m.: Lecture: Dr. D. McKenzie: External Ear.

BAKER, M. W.. M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Skin Department of St. Thomas's Hospital.

BURRELL, L. S. T., M.R.C.S., L.R.C.P.Lond. Clinical Assistant to the Ear and Throat Department at St. Thomas's Hospital.

COX. R., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Throat Department at St. Thomas's Hospital.

DAWES, H. E. T., M.R.C.S., L.R.C.P.Lond., Senior Obstetric House Physician at St. Thomas's Hospital.

FARRANT, CHARLES, L.R.C.P.Lond., M.R.C.S., Honorary Surgeon to the Taunton and Somerset Hospital.

FINCH, G., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Children's Medical Department at St. Thomas's Hospital.

GOODMAN, WILLIAM JOHN, L.D.S., Honorary Dental Surgeon to the Taunton and Somerset Hospital.

HARMENS, W., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Ear Department St. Thomas's Hospital.

HUMPHREYS, H. E., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Children's Surgical Department at St. Thomas's Hospital.

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JENNIN, N. W., M.R.C.S., L.R.C.P.Lond., Junior Obstetric House Physician at St. Thomas's Hospital.

MEADOWS, ROBERT THORNYON, M.D., C.M.Edin., D.P.H.Eng., Medical Officer of Health by the St. German (Cornwall) Rural District Council.

MORRELL, R. A., M.R.C.S. L.R.C.P.London., Ophthalmic House Surgeon at St. Thomas's Hospital.

PARSONS-SMITH, B. T., M.B., B.S.Lond., M.R.C.S., L.R.C.P. Lond., Clinical Assistant to the Skin Department at St. Thomas's Hospital.

PARSONS-SMITH, E. M., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Eye Department at St. Thomas's Hospital.

PAYCE, A. M., M.B., B.S.Edin., Resident Medical Officer of the Sanatorium of the Leeds Association for the Prevention and Cure of Tuberculosis at Gaseforth, near Selby.

ROBSON, H. A. H., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Mental Department of St. Thomas's Hospital.

ROSSITER, HAROLD T., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Mental Department of St. Thomas's Hospital.

ROSSITER, HAROLD T., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Children's Medical Department at St. Thomas's Hospital.

THORNYON, F. R., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Children's Medical Department at St. Thomas's Hospital.

WADE, REGINALD, M.R.C.S., L.S.A., Medical Officer of Health for Highbridge (Somerset.)

## Bacancies.

Middlesex County Asylum, Napsbury, near St. Albans.—Fourth Assistant Medical Officer. Salary, £160 per annum, with furnished apartments board, washing, and attendance. Applications to the Medical Superintendent.

North Riding Asylum, Clifton, York.—Junior Medical Assistant. Officer. Salary, £150 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Surrey County Lunatic Asylum, Brookwood, near Woking.—Third Assistant Medical Officer. Salary, £150 per annum, with board, lodging and laundry. Applications to the Medical Officer. Salary, £150 per annum, with board, lodging and laundry. Applications to the Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to the Clerk to the Board, Embankment, London, E.C.

Royal Victoria Infirmary, Queen Victoria Road, Newcastle-upon-Tyne.—Pathologist and Lecturer on Pathology to the University of Durham College of Medicine. Salary, £400 a year. Applications to the House Governor, Royal Victoria Infirmary, Newcastle-upon-Tyne.

St. Bartholomew's Hospital. E.C.—Assistant Pathologist. Salary.

Newcastle-upon-Tyne.

St. Bartholomew's Hospital, E.C.—Assistant Pathologist. Salary, E300 per annum. Applications to Thomas Hayes, Clerk.

Fermangh County Hospital.—House Surgeon. Salary, £72 per annum. Applications to Secretary, C. Wilson. (See advt.).

MORTON.—On March 10th, at The Lodge, Southbourne Road, Bournemouth, the wife of James R. Morton, M.B.Lond., M.R.C.S., L.R.C.P., of a daughter.

Van Praagh.—On March 13th, at 3, Honeybourne Road, West Hampstend, the wife of Dr. Harold Van Praagh, M.D.Lond., a son (Gordon).

# Marriages.

HOWLETT—LANKESTER.—On March 10th, at St. Nicholas Church, East Dereham, John Kitton Howlett, B.A.Camb., L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glasgow, third son of John Godfrey Howlett of Bracondiale, Nowich, to Nellie Elvira Lankester, eldest daughter of Egbert Rougier Early, of The Firs, Southampton.

TOMEINS—STANION.—On March 10th, at the Parish Church, Morden, Surrey, Charles P. Tomkins, L.R.C.P.I., of Epsom, to Maud Cornelia, daughter of the late John H. Stanton, of Stubb House, Winston, Darlington.

## Beaths.

EDWARDS.—On March 11th, at Higheroft, Chippenfield, King's Langley, Edward Noble Edwards, M.R.C.S.Rng., L.S.A., and V.D., late Colonel commanding 1st Sussex A.V., Brighton. GRIPHTINS.—On March 8th, at Whitehall, Knighton, Badnorshire, William Hughes Griffiths, M.R.C.S. and L.S.A., late of Hinckley, Leicestershire, in his 70th year.

HARDT.—On March 8th, at Aden, of sleeping sickness, on the voyage home from Nyassaland, Captain Frederick Hallam Hardy, R.A.M.C., aged 35, son of Major-General F. Hardy, C.B., York and Lancaster Regiment, Shawford, Winchester Sumprer.—On March 5th, at Dorking, Eustace Wyatt Sumpter, M.B., B.S., and L.D.S., third son of the late Walter Sumpter, M.D., and of Mrs. Sumpter, Cley-next-the-Sea, Norfolk, aged 33.

DICKINSON.—On March 14th, at West Hill, Putney, Charlotte Annie, wife of William Gilbert Dickinson, M.D. WALKER.—On March 14th, at 205, Peckham Bye, of double pneumonia, Charlotte Henrietta, aged 78, wife of J. Wm. Walker, M.D.



### Influenza. **Treatment** of

### **ANTIPYRETICS** RHINITIS ANTIPYRINE (Phenazone) **ACONITE** C.C.T. No. 220 = 1 minim, and C.C.T. No. 221 = 5 minims of physiologically standardised tine-ture. T.T. No. 713 and C.C.T. No.:132-C.T. No. 111 = 3 grains. C.T. No. 112 = 5 grains. Powd. Camphor . . . . 1/2 gr. Quinine Sulphate . . 1/2 gr. Fl. Ext. Belladonna Root 1/4 min. ASPIRIN AMMONIATED QUININE RHINITIS C.T. No. 278 = 5 grains. T.T. No. 644 and C.C.T. No. 133. C.C.T. No. 400 = 1 fluid drachm of tineture. Half strength of preceding. FEBRICULA AMMONIATED QUININE COMP. C.C.T. No. 197. SALICIN, 5 grains (C.T. No. 39) Quinine Hydrobromide 2 gr. Ipecao. and Opium Powder 2 1/2 gr. Aloin ... 1/8 gr. Calomel ... 1/8 gr. Powd. Capsicum ... 1/2 gr. Aconite Tincture ... 3 1/2 min. C.C.T. No. 401. SODIUM SALICYLATE C.C.T. No. 301 = 3 grains. C.C.T. No. 139 = 5 grains. C.C.T. No. 354 = 5 grains from natural salicylic acid. **ANALGESICS** ANTI-CATARRHAL ANTISPASMODICS Indicated in excessive cough and in ACETANILIDE ADRENALIN INHALANT intestinal pain. C.C.T. No. 1=2 grains. C.C.T. No. 2=5 grains. ADRENALIN CHLORIDE CHLOR-ANODYNE ## ANODYNE | Sach fluid ounce contains: | Morph. Hydrochlor. 2 7/8 gr. | | Fl. Cannabis Indica. 46 min. | | Dil. Hydrocyanic Acid Chloroform . 46 min. | | Oli of Peppermint 1 1/2 min. | | Tinct. Capricum . 1 1/2 min. | | OMNIDE COMPOLIND SOLUTION PHENACETIN CHLORETONE INHALANT C.T. No. 274 = 5 grains. These are conveniently administered PHENACETIN AND CAFFEINE by the "Glaseptic" Nebuliser. C.T. No. 273. Tinct. Capricum ... 1 1/2 min. BROMIDE COMPOUND Blixir No. 127. Bach fluid ounce contains: Chloral ... ... 120 grs. Potassium Bromide ... 120 grs. Ext. Cannabis Indica... 1 gr. Ext. Hyoscyamus ... 1 gr. Phenacetin .. .. 2 1/2 gr. Caffeine .. .. 2 1/2 gr. CORYZA T.T. No. 722. ANALGESIC BALM .. 1/2 gr. .. 1/2 gr. .. 1/64 gr. .. 1/2000 gr. Menthol, methyl salicylate and lanoline. Indicated in frontal neuralgia. LAXATIVES GRAN. EFF. SALINE ALOIN AND PHENOLPHTHA-LAXATIVE LEIN CO. Pul No. 974. CASCARA EVACUANT

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Strychnine			1/80 gr.
Extr. Belladonna	Lei	vee	1/12 gr.
Powd, Ipecac.			1/15 gr.

# RECUPERATIVES

# HEMATIC **HYPOPHOSPHITES**

Each fluid ounce contains:

Potassium Hypophosphite,	1 1/2 grs.
Manganese Hypophosphite,	1 gr.
Strychnine Hypophosphite,	1/8 gr.
Iron Hypophosphite,	1 1/4 grs.
Calcium Hypophosphite,	l gr.
Quinine Hypophosphite,	7/16 gr.

C.C.T. = Chocolate-coated Tablet.

HYPOPHOSPHITES AND QUININE COMPOUND

C.T. No. 27.

Quinine Hypophosphite		1 gr
Ferric Hypophosphite		1/2 gr
Calcium Hypophosphite		1/2 gr
Sodium Hypophosphite		1/4 gr
Potassium Hypophosphite		1/4 gr
Manganese Hypophosphite	• •	1/4 gr
CT - Compress		- b.l.s

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Sodium Glycerophosphate		16	grs.
Iron Glycerophosphate	1	1/2	grs.
Manganese Glycerophosphate		-'n	er.
Quinine Glycerophosphate		1/2	er.
Strychnine Glycerophosphate	1	1/16	ET.

T.T. = Tablet Triturate.

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, MARCH 24, 1909.

No. 12.

## Notes and COMMENTS.

Women and the R.C.S.

THE new by-law permitting the Royal College of Surgeons of England to admit women to its examinations has been published, and will come before the Council at

its meeting next month, when, presumably, it will be passed with little or no alteration. For the wording of the proposed by-law merely carries into effect the already-expressed view of the Council, and there is nothing particularly new and startling in it. The first section lays down that women may be admitted members and Fellows of the College and licentiates in dental surgery, and that in the other by-laws and regulations all words imputing the masculine gender shall also impute the feminine. The second section defines the condition that women shall not be eligible for seats on the Council, nor take part in elections to the Council, nor attend any meeting of Fellows or of Fellows and members, unless purely scientific meetings. Finally, the third section forbids women to be elected examiners. It remains to be seen what value women will attach to these privileges: we should imagine very little, except that of admission to the fellowship examinations. If, however, they enter in any numbers for the membership, we see a vista of struggles for the abrogation of the offensive restrictions placed on their sex, and we cannot help thinking that if the College was going to do the thing at all, it might as well have done it properly.

A Woman's College.

THE strong feeling which exists among the present members that they should be represented on the Council-a feeling with which, as a matter of common justice, we are

entirely in sympathy-may to a certain extent be dissipated by some of the members joining the cause of the women, and seeking to have the sex disqualification removed, and probably the idea that this result might come about acted as an argument with some members of the Council in admitting women. The justice of admitting members to the Council is so obvious that it is impossible to find any argument to repel it, and opponents are bound to rely on tradition and prejudice. Even tradition itself is against them, for members once composed the whole corporation, the Fellows being a mushroom growth of the last half century. But if members are gallant enough to espouse the feminine cause, they will lose sight of their own wrongs, and the College can certainly be relied on for many years to exclude women from governmental places. For our part we cannot see why women should wish to come into the College on the terms proposed. They are a large body and their numbers increase. Why do they no tstart a college

of their own and obtain power to grant their own degrees? Such would certainly be the more dignified course, and examination fees-at College of Surgeons rates—should be sufficient to meet all current expenses.

THE isolation hospital is a sort of Claim Against Ishmaelite amongst that most necesan Isolation sary class of administrative organisations to which it came as a late

recruit. An institution of this kind is looked upon as fair game by every litigious citizen who can formulate a grievance in connection with its sphere of activities. The complainant in an action tried last week at Winchester Assizes may, or may not, have had reasonable grounds for the belief that his little girl contracted diphtheria from an adjoining infectious diseases hospital, but Mr. Justice Ridley dismissed his claim as visionary. The facts were that the plaintiff lived in a house and grounds near Alton with his family and five children. In the summer of 1908 there had been a serious outbreak of diphtheria, and an isolation hospital had been erected adjoining the plaintiff's land. On September 25th one of the plaintiff's children, aged seven, caught diphtheria. On September 21st she had played in her father's field, and crawled under a wire fence, and had approached the hospital where the infected children and the nurses were. She had played with a kitten which originally had lived in the infected hospital.

THE medical evidence in favour of A Thousand-and- the claim was not of the strongest. one Channels It was alleged, for instance, that of Infection, the diphtheria bacilli may have

been discharged by coughing upon the grass of plaintiff's land where the little girl played. The defence urged that there was no proof that the little girl caught the disease by reason of the defendants' fault, and it was necessary to prove that fact affirmatively. Further, the hospital had ceased to exist before the issue of the writ, for the buildings were only used up to October 1st, and it was contended that the defendants had fulfilled all the requirements of the Local Government Board. Apparently the strongest point for the plaintiff was that the absence of a high wall was evidence of some negligence for the jury to consider. Mr. Justice Ridley held that there was no evidence of negligence to go to the jury, for the child might have got the infection in a thousand different ways. He would therefore enter judgment for the defendants with costs, and would certify for a special jury. We are glad to add that the judge refused stay of execution. It is to be hoped that the result of this case may serve as a warning to would-be litigants of a similar order.

An exceedingly interesting paper
Periodicity in was lately read before the Royal
Human Society by Dr. Walter Heape on
Reproduction. some points contained in the vital The numbers statistics of Cuba. dealt with are large, namely 177,704, so that the conclusions are likely to be well-founded. It seems that the ratio of males to females born of white parents is definitely higher than that of those born to coloured people. Of all births, 108.44 males to 100 females is the ratio for whites, and 101.12 males to 100 females for coloured. Again, the ratio is markedly disturbed in the case of legitimate and illegitimate births. In whites, legitimate births show 100 male to 100 female births, illegitimate 105.95 to 100 females; for coloured, there are 107.73 legitimate male births to 100 female, whilst in the case of illegitimate births the proportion is reversed, for there are only 97.91 males to 100 females. Still more curious is the fact that for both races there are two sharply-defined breeding seasons each year, and these seasons are accompanied with marked climatic conditions; such periodic breeding has been hitherto regarded as one of the perquisites of the lower animal kingdom. Also it is shown that at these times of greatest fertility the largest proportion of females are born. We hope that Dr. Heape will continue his studies on these interesting phenomena.

Lead as an Abortifacient.

From the report of an inquest held last week at Sheffield it seems that the abominable practice of selling pills containing lead for the purpose of procuring abortion is still carried

on. A labourer's wife, aged thirty-three, was admitted to the Sheffield Royal Hospital suffering from lead-poisoning, from which she succumbed. The unhappy woman was the mother of nine children, six of whom were living, and it seems that from some source she had obtained diachylon pills to rid herself of a tenth child which she was The husband said he knew nothing about the pills, and no evidence was forthcoming to show how they were obtained, though the woman had told the house-physician that she took four pills a day for a fortnight. It is shocking to think that this criminal and highly dangerous trade can be carried on, and considering all the attendant circumstances, it seems to us that the Government would be acting in the public interest if they made it an offence to sell or dispense lead, except by medical prescription, not to be repeated unless countersigned. Most so-called abortifacients are useless, and their criminal administration does little harm, but with lead the case is different, and the risk, not only of abortion, but of death of the mother, is tremendous.

# LEADING ARTICLES.

THE MEDICAL INSPECTION OF SCHOOL CHILDREN.

The general principle involved in the medical inspection of school children has been treated with acclamation by the medical profession; clearly it is only by enforcing a system of inspection that remediable defects can be brought under control and, as far as possible, remedied. Compulsory registration of this knid, however, is surrounded by many difficulties, involving as it does the expenditure of large sums of public money and a certain amount of interference with parental rights, to say

nothing of the national desire, both of local authorities, and of the central Board of Education, to avoid as far as possible any odium arising out of the matter. The whole administrative problem is still in its tentative stages, and time and experience will be needed to evolve a sound system out of the present defective and, in some instances it may be feared, even uninformed and conflicting essays. In another part of the present issue of the MEDICAL PRESS AND CIRCULAR appears an important communication on the subject from Dr. George Carpenter, who therein recounts his experiences as a medical examiner appointed to inspect some hundreds of school children in a London suburb. The Board of Education, in a Circular dated January 23rd, 1908, refrained from issuing a complete set of forms of examination, thinking it expedient to leave considerable latitude in regard to the particular forms or schedules. The Board, however, issued a schedule indicating particulars, attention to which they regarded as constituting the minimum of efficient school inspection. In adopting this attitude the Board clearly threw the onus of responsibility for any odium that might arise upon the shoulders of the local authority. Dr. Carpenter appears to think that such was the deliberate intention of the Board. Their official schedule was of a far-reaching nature, and in order to meet its requirements, he drew up a practical form for his own guidance. The children were undressed, wrapped in a blanket, and a thorough examination made in the best room that could be obtained for the purpose. The local education authority appeared to think that to undress children for the purpose of medical examination was superfluous, and that the heart could be auscultated by exposing a small area of skin in the neighbourhood of the left nipple. It must be clear to every medical man that it would be impossible to undertake any satisfactory physical examination of a child without removing the clothes. The presence of pediculi, of hernial protrusion, of bone affections, and of many skin diseases, to take a few instances, could not be ascertained in any other way. Yet the Board of Education have apparently left this crucial matter to be fought out between the local authorities and the inspecting medical officer. As Dr. Carpenter very pertinently remarks, if the medical examiner did his duty properly and the parents objected he need expect support and encouragement neither from the local authority nor the Board of Education. If, on the other hand, he did not perform his duties properly, his functions were parasitic rather than medical, and he became an unnecessary burden upon the rates and the taxpayer. These views appear to be cogent and sensible, and we fail to see how they can be disregarded by the Board of Education. A central authority of that importance should be prepared to accept the full responsibility of the details of the measures they are called upon to administer. No matter how earnest and competent the men appointed as medical examiners, they cannot be expected to maintain a high standard unless they have the support of the Board of Education. Nav. more, we hold a strong opinion that the Board is morally responsible for the forming of a fully detailed schedule, general and particular, for the

guidance of school examiners. In no other way can we imagine a permanent solution of the administrative difficulties that beset the way of securing an efficient national service. At the same time we would implore the Board of Education to take some steps to secure medical men of special experience as medical examiners. In spite of the utmost respect for the excellence of the public health service of the United Kingdom, we doubt if the average medical officer of health is qualified by previous experience for the inspection of school children. Such a post requires a long and special experience in dealing with disease, and in cases where feasible should be entrusted to men who have acquired their knowledge in responsible hospital practice. In conclusion, the Minister of the Board of Education may be congratulated on the excellence of the work that has been so far accomplished in the administration of one of the most important social advances of modern times. It is only by free discussion and enlightened criticism that the best results will be obtainable. With that end in view we have thought it well to call attention to the subject in the columns of a medical journal After all said and done, the principle of medical inspection of school children found its genesis in the work of the medical profession, and its success or otherwise in practice will depend to no small extent on the conditions attached to its services by the President of the Board of Education.

## A NATIONAL HOMŒOPATHIC FUND.

Last week at the Mansion House was held a meeting, under the presidency of the Lord Mayor, to forward a scheme for providing a national homœopathic fund. The gathering brought together an odd mixture of big-wigs, aristocratic, legislative, and religious, who surely can never have before met on a platform, together with representatives of twenty-two provincial towns. Lord Cawdor, who seems to combine a faculty for ruling the King's Nav-ee with a taste for the infinitesimal dose, defined the objects of the desired fund in a resolution which, it is needless to say, was passed nem. con. This fund is to assist in the support of homœopathic institutions in the United Kingdom, and in the foundation, maintenance, and endowment of new homoeopathic hospitals, cottage hospitals, and dispensaries in the United Kingtom, and institutions which include amongst their objects support for research into the problems of medicine on homeopathic lines, provision for homoeopathic medical education, the foundation of homoeopathic hospitals for infectious diseases, the establishment of special convalescent homes in situations where they will be available for the homoeopathic patients in large areas, and the establishment of open-air sanatoria, where the medical treatment will be homœopathic. This all sounds very fine and praiseworthy, but we fear the £7,590 18s. 4d. raised at the meeting will not go very far in carrying out such an ambitious programme. Perhaps, however, it is just as well, for now that the homoeopaths have stolen so much of our thunder (even to open-air sanatoria!) there could be nothing but confusion in the public mind if the fund were to start schemes of the sort. As Lord Cawdor said, homoeopathy is not a matter for argument or discussion; it is a matter they

(homœopaths) knew in their daily lives. That is indeed so; it is only by a kind of divine fervour in the breast that homeopathy can find acceptance; it will not stand a moment's scientific argument or discussion. The Lord Mayor, in his opening speech, said that they had not met in any spirit of hostility to orthodox medical practice; on the contrary, they had met to help that practice. Many medical men were sceptical as to the use of drugs, and therefore the time was ripe for calling the attention of the public to the system and practice of homoeopathy. We cannot say that we see anything very friendly in so doing. If medical men are sceptical as to the use of drugs, we cannot see how it will help the "orthodox' practice of medicine to ask the public to be equally sceptical about it, and rush into the extended arms of the homoeopaths. Indeed, the argument seems to be conceived in about as friendly a spirit as if he had said that, because some people think we have not enough Dreadnoughts in England, that we throw in our lot with Germany, when we should find as many as we wanted. However, his lordship, proceeding with the same want of hostility, went on to say that orthodox medicine is a system of empiricism, whereas homœopathy is a system of precision, and that modern research in medicine is tending to prove the accuracy of the homoeopathic law, "for the best results obtained by those of the old school at the present time were obtained from the use of drugs prepared in a way which was distinctly in accordance with that law." No doubt the Lord Mayor was duly informed by his "experts" that these statements are in accordance with facts, but if we pass over the hardlyveiled insult that scientific medicine is a system of empiricism, we can at least inform him that the rest is a farrago of nonsense, and nonsense of a not very harmless type. After this, the Lord Mayor pleaded for an investigation into homoeopathy, saying that the proper thing is to abolish homocopathy altogether, if it were found to contain no truth. It is rather late in the day to ask for an investigation into homoeopathy, for every competent scientific man who has investigated the subject has long since come to the conclusion that the best thing to do with such a tissue of fine-spun crudities is to abolish it altogether. Moreover, to appeal, as the Lord Mayor did, for the brotherly reception of homoeopaths by scientific practitioners is to reverse the order of things. Homoeopaths cut themselves off from the scientific practice of medicine to devote themselves to their cult, and like to be known as homœopathic practitioners, and draw distinctions between themselves and those whom they have themselves christened "allopaths." The practice of medicine is broad and catholic, and there is no reason for homoeopaths to cut themselves off unless they wish. It is both childish and illogical to dissociate themselves from the scientific practice of medicine, and then to whimper because they are not regarded as scientific practitioners. As long as there are cranks in the world there will, we suppose, be homeopaths, osteopaths, and crowds of "paths" of all kinds, but it is comforting to think that in this country these bizarre oddities gain little hold on the general public. Homœopathy is not quite at its last kick, but it is nearing the penultimate.

# CURRENT TOPICS.

# The General Anæsthetics Bill.

For some weeks past there has been considerable debate on the subject of the General Anæsthetics Bill. Few people have any doubt as to the propriety of the principle involved, and few, outside the General Medical Council, object to the obligason to have instruction in anæsthetics made part of the necessary medical curriculum. It is certainly a slur on the efficiency of the Council in supervising medical education, that so important a subject should have to be forced on it from outside. The main point under discussion at present, however, is the question whether dentists should be exempted from the provisions of the Bill. We publish in another column an expression of opinion coming from the staff of the Dental Hospital of Ireland, dentists in the same category with medical which voices the case in favour of placing men. It is pointed out that dental students receive instruction in general medicine and surgery as well as in the administration of anæsthetics, and therefore "the same privileges could with perfect propriety be extended to dentists as are given to medical men" by the Bill. Without in any way questioning the ability and skill shown by many dentists in the administration of anæsthetics, there is much to be said for the view that the discharge of that function is a part of general medical work rather than of dentistry.

# Insanity in Criminal Trials.

WE have often commented on the unsatisfactory condition of the law as to the plea of insanity in criminal trials. The process of establishing the irresponsibility of a prisoner is both cumbrous and unconvincing. It is not often, however, that we have to note an added difficulty, brought about by obstruction on the part of the Government authorities. In the case of a prisoner tried for murder recently at Armagh Assizes-if the statements made in a letter to the press from his solicitor be correcta grave miscarriage of justice was very narrowly avoided. It appears that the solicitor, having reason to believe that the prisoner was insane, applied to the Crown authorities some weeks before the trial to have an examination made by an expert in mental disease. After considerable delay he was informed that there was no reason for such a course. Eventually, on application to the Assize Judge, at the eleventh hour, permission was given to the defence to have the prisoner examined, but in the few hours at their disposal the defence were unable to obtain the services of a medical man specially trained in mental diseases. In spite of the Crown's refusal in the first instance to admit any reason for an examination of the prisoner, the Crown, at the last moment, and after the Judge's order was given, instructed a medical expert to report on the prisoner's condition. It is unfortunate that, apparently through either official incapacity or bias, the action of the prisoner's advisers should have been unnecessarily hampered, more especially in the case of a person eventually declared insane by the jury.

## Malaria and Mosquitoes.

AVERAN's famous discovery of the parasite of

malaria has ied to results of far-reaching importance. The disease has been enormously reduced in many parts of the world, and the tropics have been rendered habitable by the partial control of their greatest scourge. It was not until 1898 that Ross, reviving the theory of Lanciso, traced the spread of the infection to the agency of mosquitoes. Since then the work of practical prevention has gone on apace. It has been waged mainly, however, against the mosquitoes themselves, an almost hopeless task when their vast numbers and wide distribution are taken into consideration. Happily there are other ways of attacking the problem, and the latest method consists in immunising mankind rather than in seeking to exterminate the mosquitoes. The plan adopted is to use quinine as a prophylactic for healthy persons, and also to prevent recurrence in persons who have been attacked. The free distribution of quinine has been adopted in various parts of Italy, and some attention has been given to its administration in pleasant forms, especially the tannate, which is comparatively tasteless and tolerated by children. In addition to this measure, the nocturnal defence of habitations is also widely adopted. Remarkable results have been obtained in Italy by the use of these two simple expedients. On the authority of Professor Celli, it is stated that the mortality from malaria in that country has fallen from 21,033 in 1887 to 4,160 in 1907. At this rate we may expect that another generation will be able to look back upon malaria as a purely historical malady, just as we now regard plague and cholera in the United Kingdom.

# State-Aided Hospitals.

THE question of State aid for charitable hospitals crops up from time to time in various parts of the Kingdom. A correspondent of the Daily News points out that a precedent exists in Ireland for the existence of State-aided and State-controlled hospitals. In the Government estimates for the coming year he cites the heading "Non-effective and Charitable Services," which grants a sum of £17,000 in aid of nine hospitals and a female orphan house in Dublin. Out of the total amount  $f_{15,850}$  goes to the hospitals, which are under the supervision of a Board appointed by the Lord-Lieutenant, who reports to Parliament annually upon their condition. The same writer gives the following account of the origin of these annual grants:-When the Irish Parliament was in existence, all the Dublin hospitals but one were in receipt of State aid. The Act of Union provided that the aid should be continued for twenty years, the idea being that at the end of that period Dublin would require no further help. But this belief was not justified, and as a result the grants were continued from year to year. In 1856 an Act of Parliament was passed fixing the amount and making it permanent. As this system is reported to work admirably, it affords a precedent worthy of careful consideration.

# Speed Limits and Medical Men.

CERTAIN privileges have been claimed from time immemorial in the case of the rights of medical men visiting patients to take short cuts over private property. The precise legal conditions of the

latitude thrus claimed have never, perhaps, been exactly defined, but the belief in its existence is, nevertheless, deeply rooted in the popular belief. The point has been raised in a somewhat different form in relation to Hyde Park. During the London season, as many people know, Hyde Park is closed to petrol-driven motors during three hours of the afternoon. Last week, in the Commons, Captain Craig asked the First Commissioner of Works whether he would consider the advisability in the public interest of altering the regulations regarding the Royal parks in order to permit members of the medical profession to pass through during the prohibited hours in motor-cars, whether petrol or electric driven; and whether special permits for this purpose could be issued. To this Mr. L. V. Harcourt replied that Hyde Park is the only Royal park closed to petrol-driven motors during three hours of the afternoon for the three months May to July. As the speed of motors in the parks is limited to ten miles, whilst the street limit is twenty miles, members of the medical profession in a hurry to reach their patients and to avoid penalties would be well advised during these and all other months to avoid the parks and stick to the streets. This answer hardly appears to meet the case fairly and squarely, and certainly will not strengthen the case of those who assume the right of reserving a public possession for the exclusive enjoyment of a particular class of society.

# The Board of Education and Medical Inspection.

THE recently-issued Report of the Board of Education for 1907-08 contains an important general statement upon the subject of the medical inspection of school children. In view of the crucial point as to the scope of the examination and the special qualifications of the examiner, the official statement of opinion will no doubt be closely scrutinised. The Board report that their experience since January 1st, 1908, when Section 13 of the Education (Administrative Provisions) Act, 1907, came into force, has confirmed their belief in the soundness of its principles. They realise that their application must vary in different localities and that many practical problems can only be solved by experience; but they are convinced of the soundness of the general lines laid down in their first memorandum (issued in November, 1907). With reference to the model schedule (issued in February, 1908) the Board remarks:—"The schedule was purposely made comprehensive and its apparently detailed character is not inconsistent with the statement that the inspection of a child should not on the average take more than a few mniutes. The experience of those local education authorities who have made substantial progress with the work has confirmed the Board's opinion in this respect." To the average medical man this allowance of time will hardly appear adequate. The Board hope to issue a special report shortly which will give detailed information as to the steps taken by the various local authorities in this important matter since the passing of the Act.

# PERSONAL.

The Queen has appointed Lord Frederick Fitz-Gerald, Lady Gormanston, and Mrs. Charles Martin (Dublin) to be members of the Council of Queen Victoria's Jubilee Institute for Nurses, the extension of the work in Ireland having rendered it desirable that the Irish branch of the Institute should have further representation on the Council.

WE understand that H.R.H. Princess Louise (Duchess, of, Arguil) will open in Liverpool on May tath: an International Congress on District Nursing, in which she takes so much interest.

THE Harveian Oration of the Harveian Society will be delivered by Mr. A. J. Pepper, F.R.C.S., to-morrow, at 8.30 p.m. His subject is: ""Thirty Years' Hospital Experience and Practice."

Dr. Edward D. Madge has been decorated by the King of Roumania with the Order of the Star of Roumania.

Dr. H. R. HUTTON has been appointed I ecturer on Diseases of Children at Manchester Royal Infirmary in succession to the late Dr. Ashby.

THE French Government has conferred the Legion of Honour upon Dr. F. S. Leclercq, an English physician, of Carlsbad.

MRS. GARRETT ANDERSON, M.D., Mayor of Aldeburg, was last week entertained at breakfast at the Midland Hotel by the Manchester Association of Registered Medical Women.

THE thirty-first ordinary general meeting of the Home Hospitals Association for Paying Patients will be held at Fitzroy House, Fitzroy Square, I.ondon, W., on Friday next, at 4 p.m., his Grace the Duke of Northumberland, K.G., in the chair.

THE National League for Physical Education and Improvement will hold a meeting at 137 Harley Street, W., by permission of Mrs. Bickerton, to-day, at 3.30 p.m. Mrs. Carl Meyer will take the chair, and an address will be delivered by Dr. F. E. Fremantle, county medical officer and school medical officer for Herts.

LORD NORTHCOTE will preside at the annual festival dinner of King's College Hospital, at the Hotel Cecil on Monday, June 21st. The Committee for the removal of the Hospital to Scuth London has received a further donation of  $f_{c1,000}$  from Messrs. W. H. Smith and Son in aid of the fund.

The Annual Court of Governors of the Seamen's Hospital Society was held on March 11th, under the presidency of Mr. Perceval A. Nairne, Chairman of the Committee. Sir Walter Hunt-Grubbe, Sir Stephen Mackenzie, Dr. T. L. Rogers, and Dr. Thomas Secombe, R.N., were elected Vice-Presidents, and Mr. E. Iydekker, Capt. E. B. Pusey, R.N., General the Hon. Sir Reginald Talbot, K.C.B., and Mr. John T. Wimble, members of the Committee of Management.

SIR ALFRED JONES, chairman of the Liverpool School of Tropical Medicine, telegraphed to Prince Auguste d'Arenberg, President of the Suez Canal Company, his congratulations on the honour paid to the Prince by King Edward, who recently decorated him with the Order of Grand Commander of the Star of India. A letter sent on behalf of the School coveyed congratulations to the Prince on the honour bestowed upon him, and also expressed appreciation of the support they so long received from him and also from the company.

In the Isle of Wight Mr. Charles Dabell, C.C., presided at a meeting of the committee appointed to promote the Island memorial to the late Dr. Groves, Medical Officer of Health for the Island, it having been suggested that according as funds permitted the memorial should take the form of a bed, a cot, or some other addition to the County Hospital, with which the late Dr. Groves was so long associated. The Chairman stated that the fund raised was well over \$300, and that after meeting the expenses incurred so far, some \$£295\$ odd was available for the memorial.

# A CLINICAL LECTURE

# TERTIARY SYPHILIS IN UPPER AIR PASSAGES.

By HORACE LAW, M.D.,

Throat Surgeon to the Adelaide Hospital, Dublin.

Our subject for to-day is some of the commoner forms of tertiary syphilis in the region of the upper air passages, &c. I do not propose to make this a complete résumé of the subject, but rather to take up some of the cases I have lately seen and discuss them. Before doing so, however, it is well that we should understand what we mean by tertiary syphilis and what are its main forms as usually seen, and which affect the region we are about to deal with.

As is well known, syphilis is divided into two main forms; the acquired, and the hereditary. The former, being divided into primary, which is at the seat of infection or relating thereto, and the secondary, in which the disease takes the general form and manifests itself all over the body, and the tertiary, where the disease has ceased to be systemic, but lights up in local inflammations from causes which are not well understood. It is generally considered that no tertiary symptom is seen until a full year has passed by from the time of inoculation; but, on the other hand, many years may elapse before these signs develop, or the patient may escape them altogether. It is often laid down that this recrudescence of the disease, if it may be so called, is due to a lowered power of resistance in the system and debility; of course, also the fact of whether treatment in the early stage has been efficient or not, is of great importance. It is sometimes stated that those cases which in their onset appear most mild may, after years of immunity, show serious lesions, most often in the nerves or brain; here also it is possible that the mildness of the original attack may have conduced to inefficient treatment, and that this may be the explanation of these cases. The forms of tertiary syphilis which come within the range of our subject are :-

- 1. Forms of ulceration of the mucous membrane, and a superficial inflammation causing silvery patches, the latter most often seen on the tongue.
- 2. Gummata; these are soft tumours composed of small-celled infiltration, which go through the stages of deposit, death due to want of blood-supply from the rapidity of their growth, and finally discharge.
  - 3. Ostitis, with caries and necrosis.

Case 1.—Man, act. about 50. He came to me complaining of very foetid discharge from his mouth in the region of the premaxilla, and pain and tenderness on trying to eat. Marked nasal trouble was absent. On examination, at first sight the line of teeth seemed complete, but on closer examination this proved to be a sequestrum of dead bone fairly loose, which had dropped down until it reached the lower edge of the teeth on either side of it. The hard palate showed a deep V-shaped ulcer, with dead bone as its floor. The sequestrum was gripped with a strong forceps and removed. When it was examined it was found to correspond accurately with the bone called premaxilla, or with that part of the upper maxilla which developes from an anterior centre. The interest in the case lies in the fact that the demarcation line of the necrosis is found to correspond with the developmental structure, and it may be looked upon as an ostitis followed by necrosis.

Case 2.—Man, æt. 30. He came to me complaining of a large red swelling over the pomum adami, which, on palpation, fluctuated. The borders of the swelling were hard and circumscribed, there was a slight pain on swallowing, but the main trouble was the external swelling. He was advised to go into hospital; after some delay he did this and the abscess was opened externally; a large quantity of pus was evacuated and a little air whistled out; this showed that the abscess had also opened internally into the larynx. Treatment consisted of boracic poultices and iodide of potash combined with mercury. Healing was rapid and no sequestrum formed, nor was there any gross change to be seen in the larynx. This was a case of perichondritis on the external surface of the thyroid cartilage, which broke down and formed an abscess, and, owing to the delay, had time to find its way internally into the air passages as well as externally, fortunately without causing necrosis of a large portion of the cartilage.

Case 3.--Girl, æt. 15. She came, complaining of nasal discharge of a horribly foetid character. After a little cleaning up, a large sequestrum, composed of the vomer, was removed, and on the next visit some more pieces were taken away. It was now possible to see that the whole septum from back to front was gone, except a small bridge of skin anteriorly. Treatment by iodide of potash and mercury in large doses was ordered, but was not carried out efficiently, with the result that three weeks afterwards the remaining bridge of skin was gone; every effort was made to persuade her to submit to treatment in vain, and a redness and sinking-in of the nose was noticed at her last visit. In this case we have the same disease manifesting a more malignant nature, not because it is essentially different in form, but owing to poor treatment, and probably lowered resisting power, possibly coupled with a severer infection.

Case 4.—Girl, zet. 12. A small, delicate-looking child, came with a large deep ulcer elongated antero-posteriorily, and showing a sequestrum in its floor. Two large pieces were removed which opened up the nasal cavity, and they proved to be pieces of the palate bone, the vomer apparently escaping in this case. The medicinal treatment was the same as above. These two last cases are of peculiar interest, as the origin of infection is open to doubt. Are they cases of hereditary disease, or of ordinary infection? If the latter, were they infected at birth, as babies, or later on? I could not extract any history worth recording, nor could I find any satisfectory evidence of true hereditary syphilis, so that I am obliged to conclude that they were infected since birth. All the above cases show the disease in a severe form.

Case 5.-Man, æt. about 50. He came to me complaining of a sore throat and pain on swallow-

The first glance into the throat showed a small ulcer on the free edge of the soft palate, whose characteristics partook rather of secondary syphilis than anything else, except for the fact that it was unilateral. No syphilitic history could be obtained, but, taking all the symptoms into consideration, it was diagnosed as a tertiary ulcer and treated by local applications of nitrate of silver, and iodide of potash internally; this rapidly produced a cure, and the patient disappeared for nearly a year; on his return he complained that his former symptoms were much worse, and examination showed a large uneven ulcer with ragged edges in the same position as the former one, but the larger part on the nasal surface of the palate and marked thickening all round it, which extended into the pillars of the fauces and over to the uvula and a little on to the posterior wall of the pharnyx. The case was taken into hospital, and microscopic examination confirmed the diagnosis of carcinoma. This case shows a not uncommon sequence, namely, the occurrence of carcinomata in old syphilitic scars. In the early stage this affection behaved much as the usual syphilitic ulcers do, and it was watched right on until no disease was seen or felt, and the subsequent appearance of cancer was not expected, though it could have been dealt with if the patient had returned when the recurrence of his symptoms began.

The milder forms, which are more commonly seen, consist of small gummata, situated in various parts, for instance, the soft palate, the posterior pillar of the fauces, the posterior wall of the pharynx, the naso-pharynx, or the septum of the nose. In all these the appearances are much the same, a punched-out ulcer with red, thickened and everted edges. The floor of the ulcer is a dirty grey colour, and unhealthy, the shape circular or serpentine if two or three separate gummata coalesce, often perforating in the palate, anterior pillar of the fauces, or nasal septum.

#### DIFFERENTIAL DIAGNOSIS

- 1. Of slight ulceration from secondary syphilis, tubercular or lupoid ulceration. The less severe forms of tertiary ulceration are in their inception, probably, occasioned by the coalescence of several small gummata, which have formed superficially, and therefore should not be regarded as different from the severer forms, where there is no doubt as to the gummatous origin. They may, however, be mistaken for secondary ulceration unless the symmetry of the latter is borne in mind, and the other secondary signs looked for; however, the secondary form is much more superficial, and does not show the loss of tissue which is a prominent feature of the tertiary. Lupoid ulceration has also to be considered, and here the same characteristics hold as in the form of the disease in the skin. It is nodular or granular, not neeply punched out; in fact the floor is often raised above the level of the surrounding mucous membrane, and the raw ham colour is often reproduced, especially on the palate.
- 2. Severe ulceration from tubercular and cancerous Gummata need to be diagnosed from tubercular ulceration and carcinoma, when we remember that the coalescence of tubercles makes a tuberculoma, which is essentially a granuloma, and also, that a gumma is a granuloma differing but little in structure, we realise the necessity of accurate observations. Strictly stated, the tuberculoma grows slowly, and does not cut off its own blood supply so quickly, and, therefore, as we would expect, we find a rapid breaking down of

the gumma into an ulcer with a dirty grey floor, thickened edges, and a punched-out appearance, owing to a loss of tissue, whereas in the tubercular form the surface is eroded away and leaves underneath a granular ulcer, whose edges are thickened and everted, but whose floor oftentimes is now below the level of the surrounding healthy tissue, and, indeed, may be above it. Finally, the chronicity of the tubercular and the rapid improvement of the syphilitic under iodide of potash will render the diagnosis clear. In the case of cancer, the difficulty of a quick decision is great, and, at the same time, admits of no delay. fashioned plan of allowing iodide of potash to decide is not advisable, if a shorter way can be found. It is not possible to lay down absolutely the characters, and often the best plan is to remove a piece for microscopic examination, though if the cancer is a recent one early operation is the right course, without waiting for anything. The many points of difference lie more in degree than in form; both are stinking ulcers, both have everted edges, but the carcinoma has generally more infiltration and hardness around it, and the glands show more enlargement. As mentioned in Case 5, the two diseases may be found together in the same patient, though not generally active at the same time, the tumour formation being superimposed on to, or arising in, the cicatrix of the former lesion.

3. Specific for simple periostitis. This is generally diagnosed by exclusion, by the history of syphilis, or by the advancement of the disease to

the next stage—that of necrosis.

- 4. Syphilitic necrosis from tubercular or simple. Is it possible to diagnose syphilitic necrosis from that due to injury or tubercle? I think so, and often from its naked-eye appearance alone. In the two latter forms above-mentioned, if necrosis takes place an abscess forms, and then, when it reaches the surface, a sinus results; while in the syphilitic form, the inflammation spreads to the soft tissues, and results in a large open sore with dead bone at the bottom.
- 5. Perforations in the nasal septum are of three kinds—simple, tubercular, or syphilitic. It is laid down—correctly, I believe—that the simple form is confined to the cartilaginous portion, while the other two extend further, and also that the syphilitic tends to attack the vomer, this being rarely or never the case in the tubercular form. Perforation of the palate is nearly always syphilitic, though lupus may eat away a portion of the posterior edge. A few cases of permanent perforation of the anterior pillar of the fauces or soft palate have been recorded, due to severe ulceration during scarlet fever.

### TREATMENT.

Local treatment, consisting of a mild mercurial wash, about a teaspoonful of black wash to two ounces of warm water for the nose or nasal pharynx, and about twice as strong for the mouth or pharynx. In the latter situations, calomel may be puffed on to the ulcer in the sublimed form, and acts very quickly. Touching the ulcer with silver nitrate is also useful, especially on the pharyngeal wall. General treatment may also be summed up in the words "iodide of potash"; but mercury is useful in the severer forms, especially if there is reason to believe that treatment in the early stages is incomplete. Treatment by injection will hardly be necessary in this stage. For the relief of pain, orthoform powder may be applied freely, or a gargle with opium in it may be prescribed, and, if cicatrisation should take place, injection with fibrolysin has been used with marked benefit.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for west week will be by Prof. A. Calcot, M.D., Physician to the Berek Institution, Paris. Subject: "Treatment of Local Tuberculous Lesions by Injections."

### ORIGINAL PAPERS.

### THE DIFFERENTIAL DIAGNOSIS AND INOCULATION TREATMENT OF TUBERCULOUS GLANDS IN THE NECK. (a)

By L. C. PEEL RITCHIE, CH.M., M.D., Research Student, Surgical Department, University of Edinburgh.

THE matter under discussion, although familiar, is yet by no means exhausted, and I propose to deal specially with an aspect of it which, as the subject of recent work, may present certain features of novelty. The diagnosis of tuberculous glands in the neck from other affections presents little difficulty in the great majority of instances. The question of suitable treatment often demands the greater consideration. A notable revival of the employment of tuberculin in the treatment of tuberculous conditions has been seen in recent years in this country. Allowing for the enthusiastic reports inevitably attending such a revival, it will probably be admitted that the results of tuberculin treatment in surgical tuberculosis are in no way amazingly successful, and are not infrequently unsatisfactory and even disappointing. Such has been my experience in a number of cases, while, on the other hand, steady, if slow, improvement to recovery, and with, perhaps, avoidance for the patient of the discomforts of operation, has been the gratifying course of events. Such conflicting results in patients similarly affected and similarly treated early attracted my attention. At first all my tuberculous cases were treated with Koch's Tuberculin R., which is prepared from bacilli of human type and origin. If, then, some of the patients were infected with bacilli of bovine or other type, it was conceivable that these were the cases which failed to respond satisfactorily to the inoculations. I therefore endeavoured to determine whether blood examinations devised to this end would serve to clear up the difficulty.

Since I first, in 1907, reported on some preliminary experiments, describing a method which served to show that the phagocytic blood reactions of tuberculous individuals might vary essentially in character, I have investigated this point much more fully along different lines. Put shortly, my conclusions amount to this that, in blood tests by means of the phagocytic index (the so-called opsonic index), using tubercle bacilli of distinctive characters, of human type and origin, and of bovine type and origin respectively, one finds that the sera of tuberculous patients show the various diagnostic reactions, some to the one type, some to the other. So far I do not happen to have met a case which gave positive reactions to both, nor any unquestionably tuberculous case which gave a negative reaction to both types. Further, inoculation of tuberculin made from the one type of bacilli affects the phagocytic index to that same type only. My deductions from this are that the blood changes in patients infected with tubercle are not all of the same character, but show certain differences, which can be readily ascertained by various applications of the phagocytic index tests such as I shall presently describe, and that these differences may be taken as indicating whether the patient is infected with the human or the bovine type of bacterium. This observation would, however, have but academic interest, for we are still far from knowing what significance phagocytosis may really have in the development of immunity to tubercle, were it not that clinical experience has shown that the laboratory tests point the way to the proper form of tuberculin treatment. By

(a) Bead before the Chelsea Clinical Society at the Annual Clinical Debate, March 9th, 1909.

that I mean that the case found to be infected with the human type of bacilli should be treated with tuberculin prepared from the human type, that infected with the bovine type with tuberculin prepared from the bovine type.

It is an interesting fact that a number of cases that I have treated myself, or which have later come under my notice, having been given inoculations of what I should now consider an inappropriate form of tuberculin, have shown a degree of improvement at first which was attributed or thought to be attributable to the tuberculin. The relapse, often severe, occurring subsequently, demonstrated that no real immunisation had been obtained. It is quite a possibility, nevertheless, that tuberculin of one type may have a partial immunising action for infections of the other type.

immunising action for infections of the other type.

Such unfortunate relapses in the absence of explanation would naturally give rise to distrust in tuberculin treatment, and I think reports on the results of this form of treatment should be reconsidered in the light of this differentiation of types. Where unexpected relapse in the course of treatment with human tuberculin has occurred in my earlier cases, it has been found that the initial diagnostic test to the human bacillary type had been negative, and regarded as possibly a technical error, whereas subsequent examination, when carried out, has shown the case to be really one of bovine infection.

As a preliminary, then, to a satisfactory course of specific inoculation treatment, three diagnostic tests are available. Two of these have already been reported on, so I shall but briefly refer to them here.

Firstly, the Inoculation test, devised by Struthers Stewart (a), which consists in giving ac injection of .002 mgrm. of tuberculin for an adult patient. On testing the blood at the time of inoculation and 24 and 48 hours after, it is found that a negative phase ensues in an infected person, but not otherwise. This reaction is apparently a specific one—that is to say, if a patient is infected with bovine tubercle, the inoculation of bovine tuberculin alone produces a negative phase, and that only in the tests with bovine bacilli, and vice versa. To make a test complete, it would be necessary toinject both types of tuberculin and test the indices to both types of bacilli. It has the disadvantage of upsetting for the time being the state of the blood should any further examination be desired, and also, for our purpose, of requiring a somewhat larger dose to be given than that with which one may care to commence a course of treatment.

Secondly, there is an Absorption test, which I have now used extensively, which gives very definite results, and is also specific in character. It consists in diluting the serum with a thick suspension of an indifferent organism. This has the effect of absorbing from all sera the non-specific substances which produce phagocytosis, while leaving the specific substances, the result of infection, to act on the corresponding bacteria when these are added to the phagocytic mixture. The normal serum used as a control, having no such specific substances, shows a reduced phagocytosis, whereas the infected serum still produces a high degree of phagocytosis of the infecting organism. As I have gone into the details of the test elsewhere (b), I shall not trouble

you further with them at present.

Thirdly, there is a test, simple in principle and application, which has been largely occupying my attention of late. I may call it the Comparative Index test. It is based on a considerable number of observations which I have made to the effect that, as against the same control, the phagocytic index of an infected person's serum is the same, within the limits of technical error, to all organisms other than the one with which he is infected. The index to that organism usually stands at a distinctly different level, whether higher or lower. It may on occasion happen to approach the same level if fluctuating, but this is, in my experience, but a rare eventuality. Instead of testing with a number of organisms, one may greatly simplify matters by testing with one indifferent

<sup>(</sup>a) Stewart and Ritchie, Edin. Mad. Jonen., May, 1907.
(b) Ritchie, Brit. Med. Jonen., Nov. 16 h, vol. ii, 1907.

crganism—that is to say, with which one may be certain the patient is not infected. This furnishes us with the patient's standard index, and it is compared with the indices to organisms suspected as the cause of infection. In tuberculous cases I would then test the patient's indices to avian, bovine, and human tubercle bacilli. The index to the avian bacillus gives the standard, and one may expect one of the other indices to correspond; the remaining variable index points to the type of infection.

This last test is, on the whole, the simplest and quickest, and, for our purpose, the most convenient, and it may be repeated at any time if desired for confirmation. It demands every attention to excluding variations from technical error, and may be less distinctive than the two other methods already mentioned.

These tests, then, furnish us, I believe; with a means of differential diagnosis with a view to inoculation treatment in cases of tuberculous glands in the neck. At the same time, of course, they provide a means of the glands and other conditions, provided there be ro other known tuberculous lesion elsewhere which might of itself give rise to the blood changes. For this general diagnosis, as has been indicated, no phagocytic index test is complete unless both types of bacilli are taken into account.

The question naturally arises here whether the cases present clinical features distinguishing them in correspondence with the results of these blood examinations. With a view to this paper I have collected my records of cases to date in the hope of gleaning some information on this point. I find that out of about 200 cases of surgical tubercle examined, there are 37 cases of glands in the neck whose records afford sufficient information to bring before your notice in this connection. In three of these cases the cervical glands were not a predominant feature in the tuberculous infection, being at the time either quiescent or having been previously removed by operation, were not causing further trouble.

Of the 37 cases, 22 were judged to be instances of human infection, 15 of bovine infection. Taking up the features in detail, first, as regards age incidence, reckoning on the ages as far as ascertainable at which the glands were first noticed. If we take 18 years as dividing those who have attained to puberty from the remainder, we find that, of the human type, 11 were 18 years and over, 11 were under that age, while of the bovine type only 4 were of 18 years and over, and 11 were under. Taking 21 years as the attainment of maturity, we find of the human type 6 cases occurring over that age, of the bovine type only 1. In such a limited number of cases numerical computations are somewhat erratic, but the general conclusion is, 1 think, justified that the bovine type is rare after maturity, and, on the whole, is more characteristically an infection of youth than is the human type.

As regards sex incidence, we find that the human type is more frequent in each sex, but disproportionately so to a slight degree in the male sex. Next as regards the occurrence of complications of a tuberculous nature elsewhere than in the cervical glands, five-sixths of the human type, and four-sixths of the bovine type present such complications. These numbers are not, then, suggestive, though the nature of the complications may be and is worth some study. I cannot enter fully into this at present, but would only point out that bone and lung affections represent the bulk of the complications in the human type, glandular, skin, and eye affections in the bovine type. As for the family history, it is a matter of regret that my information has often been incomplete. I have been surprised, however, to find how seldom a history of tubercle was obtained, and the interesting observation remains that in the only three instances in which I have got definite particulars of gland tubercle in the family the affections have been of the bovine type, and in the only two instances obtained of phthisis in the family the affections have been of the human type. Case No. 7 is interesting in this respect. The patient, æt. 22, first suffered from tuberculous glands in infancy, and the father died of phthisis when she was two years old.

Next, with regard to the duration of the disease in the glands, no very definite conclusions can be drawn from a list of cases first seen at various periods of their illness. An accurate estimate can only be made from cases after final recovery. It may be mentioned that, though their total number is fewer, more of the bovine cases gave a history of over one year's duration. This may be taken as meaning that, on the whole, there were more acutely developing cases of the human type requiring attention, and that more of the bovine type had been left to a hoped-for spontaneous recovery. I can also record that this corresponds to the general impression I have now formed that the bovine type of surgical tubercle tends to be of a slow, chronic character, often intractably persistent, while the human type is frequently associated with the more acute forms of disease. But this is by no means exclusively the case.

The occurrence of liquefaction in the glands, or the persistence of discharging sinuses after operation, affords a more definite subject for consideration. As far as these records permit it, we find that these features developed more frequently in the bovine than in the human cases in the proportion of 4 to 3. Of course, the possible occurrence of secondary infection may influence this estimate. It is, however, further suggestive of the idea that the bovine affections furnish the more persistent chronic cases.

It is apparent from this review that while the clinical features of the two types may have certain special tendencies or characteristics, these are not yet definitely enough ascertained to permit of a differential diagnosis being made with any feeling of surety on these clinical This may be a possibility in some, grounds alone. though not in all cases, in the future, when more numerous and representative data are available. It is certainly difficult to decide what constitutes a representative series of cases. For instance, a children's hospital would conceivably supply a greater proportion of bovine cases than appears on my list. Again, the great majority of private cases of surgical tubercle which I have examined are of bovine type. Then, too, my list is influenced by the considerable number of adult cases, probably subjects of early phthisis, cases appearing at the surgical out-patient department of a large general hospital (the Royal Infirmary of Edinburgh). One may surmise that, while hospital patients and those of the better classes are almost equally exposed to food infection, those of the better classes are much less frequently exposed to and also better guarded against infection from phthisical individuals. The frequency of the human type of infection among hospital cases may thus be explained, and it is interesting to note that many of these cases are noted as factory workers, miners, and plumbers. It is also a possibility to be kept in view that the types of cases may vary in different localities.

At present, then, one must regretfully admit the necessity of falling back upon the methods of blood examination to determine the appropriate tuberculin treatment. First of all, then, in this connection, the technique of administration demands a word or two. The most suitable tuberculin, in my opinion, is Koch's Tuberculin R., and this is now to be obtained commercially made from either human or bovine types of bacilli as may be desired. I recommend diluting the tuberculin as sent out with .9 per cent. sterilised saline. Glycerine should not be used This is filled into small sterile flasks fitted with rubber stoppers. A few drops of chloroform are added, and renewed as evaporation takes place. The chloroform, on being shaken up, partly passes into solution and serves to maintain the sterility of the fluid indefinitely. The most suitable dilutions depend on the dosage to be given, and for the comfort of the patient it is desirable to inject the smallest quantity of fluid that can be accurately measured in the syringe. The injections should be made with a syringe accurately marked, which can be sterilised by boiling, and is fitted with thin I in. platinum needles. As accuracy of dosage is of such

prime importance, it is desirable to work with the metric system and to use a syringe marked in divisions of I cubic certimetre, and I may mention that syringes made abroad and marked in minim measure are frequently very inaccurately calibrated. The injection should be made directly into the substance of a muscle. I find that the middle of the triceps in its lower fourth, or in children the gluteus, are the most convenient sites, but any other suitable mass of muscle may be chosen. Following this technique I have never found any trouble resulting.

As regards the dosage, there are certain general principles which need to be observed to avoid possible causes of ill-success. First, the more acute and active the development of the disease, the smaller should be the dosage. The smaller the dose the shorter is the duration of its action. There is nothing to be gained in the end by an attempt at rapid immunisation. initial doses should be given at comparatively short intervals to avoid the production of a condition of hyper-susceptibility. For the same reason no dose should be smaller than any preceding one. If a dose given is thought to be too large, it should not be diminished, but a longer interval than otherwise is allowed to elapse before the next is given On the other hand, it is probably not necessary to increase to any extent a suitable dose. As the condition becomes quiescent, and passes under control, the interval may be lengthened and the dose slightly increased. The ideal dosage is, to my mind, that which, without causing any obvious reaction, produces the most pro-longed effect. The doses must be steadily continued, not given at hap-hazard, and treatment should never be started unless its continuance has been arranged for.

Following out these principles in the treatment of a chronic case of tuberculous glands in the neck in an adult, one would give a dose of .oot milligram of the appropriate tuberculin; repeat the same dose in two weeks, then in three weeks, and then at successive intervals of four weeks. After at least six months or more had elapsed, one might then, if the case had progressed satisfactorily, extend the interval to five or six weeks, and increase the dose by a quarter or a half to .00125 or .0015 mgrm., and continue with this to the end of treatment. Under these circumstances there is no necessity of giving the patient a "rest" from the inoculations.

In a strictly chronic case such a course as this will manifest its results in a slow but steady improvement, without any effects being directly noticeable from the injections. If the condition, however, is active or progressive, such a dosage may give rise to an increase of inflammation at the seat of disease, so if a gland is already breaking down, the liquefaction may be augmented by collection of serum and the abscess point more rapidly at the surface. In many cases this is inevitable when the disintegration has occurred to any appreciable degree, but, at any rate, it is desirable to proceed more cautiously at first. Accordingly, the initial dose should be a half or a quarter of that mentioned, depending on the acuteness of the disease. The second dose is given after a week or ten days, the subsequent doses at intervals of three weeks, and, if progress is satisfactory, these doses are increased till, after, perhaps, two or three months' treatment, dosage falls into line with that described for quiescent condition.

The doses stated are those for an adult. For younger people they must be proportionately diminished, and one would accordingly do well to give three-quarters the amount to a patient under 20 years, half the amount to one under 14, and so on. An infant would get onetenth or one-twelfth.

These doses, as I should mention to avoid confusion, are based on the original and correct calculation of Koch's Tuberculin R., as sent out, containing the active properties of 10 milligrams' weight of bacteria per 1 c.cm.

We have now to consider the results of treatment on these lines in the various conditions of glandular tubercle as they present themselves to us, for the course of events is largely dependent on the actual state of the glands at the time when treatment is commenced. If tuberculous glands are treated in the earliest stages the result should be particularly satisfactory. have been reported in which glands have rapidly disappeared after actually but one or two injections of tuberculin. I have not myself seen any such case, and I have considerable doubt as to the possibility of tubercle having been the cause of the enlargement. A tuberculous infiltration is not to be so simply and rapidly resolved, while from the practical point of view we must recognise that before tuberculous glands draw any attention to their condition, the degree of infiltration and involvement is already extensive, and caseation in all likelihood has taken place in at least some of them. It is this caseation that is the stumbling-block in recovery, for though extension of the disease is readily enough controlled, the removal of the caseous material is probably not specially aided, and is only attained after a considerable lapse of time, while it may long continue to harbour bacilli still capable of development should opportunity offer. In caseous glands, then, one must look forward to a prolonged course of treatment to ensure recovery.

If periadenitis is present, one finds that it shows rapid improvement, and after two or three injections, a mass of glands, at first indefinite in outline, becomes altered so that the individual glands can be readily felt. I have several times seen it stated in print that the beneficial effect of tuberculin injections is to render the glands softer and smaller. This seems to me toindicate either an incorrect diagnosis or a misconception of the pathological processes taking place, and of the aims of treatment. A tuberculous gland, unless calcified, is already soft and succulent, and may be caseous or semi-fluid from liquefaction. In the process of natural recovery which tuberculin only further aids, the gland loses its inflammatory exudation, shrinks, becomes smaller and firmer, and, when healing is complete, abnormally hard and fibrous. If a gland, then, under treatment becomes softer, one may anticipate that liquefaction is occurring, but in this case the gland increases in size. As I have mentioned, the inoculations may seem to bring about this condition, but my impression is that they only hasten a process-which has already commenced. It is not, indeed, an altogether undesirable incident, though, to avoid distrust, it is well to warn the patient of what may happen. If the accumulation is near the surface, it may be removed by puncture with a trocar, and this may require to be repeated if the cavity is a large one, or a small drainage tube may be inserted temporarily. As the re-accumulated fluid is usually for the most part serous, the administration of calcium salts deserves trial in order to diminish the amount of exudation. The outcome is often very favourable, as a large collection of tuberculous material is removed much morerapidly than could have taken place by absorption, and only a hardly visible puncture scar remains. In any case the tuberculin treatment should not be interrupted.

If, however, the patient does not come under observation till the skin is already itself infiltrated and thinned, surgical measures must, of course, be considered with a view to avoiding ulceration and disfigurement. In the presence of sinuses or secondary infection due to the presence of pyogenic organisms, inoculation treatment against this may, with advan-

tage, be combined with the tuberculin.

If tuberculin treatment is to be relied upon, onemust be prepared to carry out the inoculations for a minimum period of six months in the most favourable cases, and, as it should be made a rule in tuberculousdisease to continue the injections for a considerabletime after the obvious signs have gone, one may count on the advisability of treatment for a year. In cases where extensive caseous deposits have already formed, still longer treatment is probably necessary. To judge of progress, one must neglect day-to-day variations, which are often considerable in caseous glands, and decide rather whether from month to month there is, on the whole, a steady improvement and diminution in the size of the glands.

Such prolonged treatment may seem burdensome and

a tax on the patience of the invalid and the medical attendant. Following such a scheme of inoculations as I have mentioned, however, it is not really so, as the injections are given at considerable intervals, and by routine, and do not necessitate constant supervision of their immediate effects. It should be quite possible, therefore, to give hospital patients attending even a busy out-patient department the benefit of tuberculin therapy on these lines. It should not be adopted, how-ever, in patients ill-cared-for or insufficiently nourished. The usual medical treatment of a tonic The usual medical treatment of a tonic nature may, with advantage, be combined in the attempt to assist the natural powers of recovery, and I would specially emphasise the enormous benefit derived from transferring town children to the country, if only even for a short change. Of local methods of treatment I would but refer to the application of heat, which, in theory, at any rate, should be beneficial.

This is most conveniently carried out by the use of small, flat sandbags, heated as hot as can be comfortably borne, and applied to the neck at night when the patient retires to bed.

While I have dealt here specially with inoculation treatment, I should not wish it to be thought that I am opposed to operative measures, or even consider the two methods of procedure antagonistic. They can, in fact, well be combined. The attractiveness of attaining by mechanical removal within a few days a result for which natural processes demand as many months is undoubtedly great. But, with regard to operations in tubercle, there are two features to which special attention should be drawn. In the first place, there is the great probability that tuberculous infection is more widely distributed throughout a patient's body than is evident on the surface, or discoverable by the means at our command. Enlarged glands in the neck may be, therefore, but the outrop, so to speak, of a stratum of hidden glandular tubercle. A radical operation in the neck, therefore, even if that term is really justifiable, may be radical only in a local sense. To perform such an operation on a patient extensively affected is to speculate freely on their powers of resistance to the disease. In the second place, there is the further pro-bability that operative interference in a tuberculous area may readily lead to a dissemination of the bacteria to other parts of the body as well as that operated on. This is, perhaps, specially likely to result from a curetting operation, but may occur under any circumstances in which tuberculous foci are laid bare. are comparatively few operations in which tuberculous lesions can be removed in toto by cutting only through healthy tissues, and this is not probably the case in gland operations. That this possibility of spread of the disease by operation is a notable one I am firmly convinced. I do not refer merely to those cases of meningitis and acute miliary tuberculosis ending in death occasionally occurring in consequence of operations, which are already recognised as they could hardly fail to be! I refer rather to cases of localised infection occurring at a distance, it may be, or close at hand, which, as with most tuberculous lesions taking some time for their development, are less likely to be attributed to the preceding operation. Such patients one hears spoken of as having tubercle in their "system," so that they are always developing some fresh trouble. They bulk very largely among the cases of multiple surgical tuberculosis which crowd the out-patient departments of our hospitals. I have so constantly found that each new appearance of disease was a sequence of a shortly preceding operation that the only conclusion feasible was that the two incidents were interdependent.

Looking upon tuberculin treatment as having little effect on caseous deposit of tubercle, and therefore of chief value as a prophylactic measure which guards against extension, I should be inclined to recommend that, unless abscess formation already existing demands immediate attention, operative procedures should be deferred, if permissible, till a course of tuberculin treatment has been initiated. As experience has shown that one or two inoculations are insufficient to protect against extension after operation, the patient should

be treated for a period of, say, at least six months. The question of operation may then be reconsidered. Possibly a radical removal may not be called for. Whether or no, the surgeon may expect to find the condition of the glands much more favourable for operation than formerly, and he is taking less risk as to the possible prejudicial results of interference. For the reasons already stated, the inoculations should be continued till recovery is finally ensured.

#### ON THE

# EARLY DIAGNOSIS AND SURGICAL TREATMENT OF CANCER OF THE STOMACH. (a)

By D'ARCY POWER, M.A., M.B.Oxon., F.R.C.S.Eng.

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I have been looking through the notes of cases of cancer of the stomach which have been under my care, and it is clear that in hospital practice patients are not treated until late in the disease, whilst in private practice those who prove to be suffering from cancer of the stomach are not willing to be treated for anything more than indigestion, until bleeding or the discovery of an abdominal tumour gives clear evidence of the nature of the mischief.

The early symptoms of cancer of the stomach are identical with those of the chronic ulceration to which I believe it is nearly always secondary, just as epithelioma of the lip is secondary to the chronic irritation caused by a foul pipe, or cancer of the tongue to the changes produced previously by syphilis. Cancer of the stomach usually developes very slowly, and is localised for a long time to the part of the stomach where it begins. Secondary growths are not the rule, and even where the lymphatic glands are enlarged in the immediate neighbourhood of the stomach, microscopical examination in several cases has not shown the existence of any epithelial deposits, but only the hypertrophy of chronic irritation. In all my cases of cancer of the stomach the patient was over thirty years of age, and was usually between fifty and seventy. Men and women were affected nearly equally.

I do not believe that at the present time we have any means of diagnosing cancer of the stomach with even approximate accuracy by means of the symptoms, for the same symptoms are produced by any ulceration of the stomach, whether the cause is innocent or malignant. The signs are more helpful. A test meal is serviceable both on the microscopical and chemical sides. It is not sufficient merely to estimate the amount of free hydrochloric acid on a single occasion, but the estimation should be repeated more than once. Dr. George Graham has gone farther than this in some of our recent cases of cancer of the stomach at St. Bartholomew's Hospital, for he has estimated the organic hydrochloric acid present, but as yet without obtaining any very helpful facts. In other cases I have had skiagraphs taken of the stomach after the mucous membrane had been rendered impermeable to X-rays by a coating of oxycarbonate of bismuth. The result is satisfactory in the case which I show you of advanced carcinoma, but in the early stages we were unable

<sup>(</sup>a) Contribution to a discussion at the Harveian Society, March 4th, 1909. See page 301.

to detect any localised thickening. It seems, therefore, that we are driven to actual inspection if an early and certain diagnosis is to be made, and, even then, we must beware of mistaking an innocent thickening in the pyloric region such as is produced by a duodenal ulcer for a mass of carcinoma. I do not mean by this that every case of chronic indigestion with some loss of flesh should be submitted to an abdominal operation, but that every case where there is grave suspicion should be explored, permission being obtained to remove the growth if a microscopical examination by a skilled pathologist made whilst the abdomen is open proves the mass to be carcinomatous. The farther operation would consist of a partial gastrectomy with a posterior gastro-enterostomy, an operation which is well borne by patients.

The prophylaxis of cancer of the stomach rests with those who see the patients in the earlier stages and long before they come to ask advice of a surgeon. Irritation, as is well known, not only leads to cancer, but increases the rapidity of its growth. It is of the first importance therefore in cancer of the stomach to put the organ at rest, both on the physiological and on the anatomical side. Physiologically by allowing proper food to pass into the stomach in a condition which is best fitted for its gastric digestion; anatomically, when physiological means have failed to afford relief, by exploring the stomach, removing any actual disease which may be removable as early as possible, and by performing a gastro-enter-ostomy to put the stomach at rest where this operation seems advisable. It is, I think, a very great mistake to allow a chronic ulceration of the stomach to continue indefinitely, the symptoms being masked by the administration of bismuth and carminatives until cicatrisation and the formation of an hour-glass stomach is produced. It savours too much of the old plan of keeping wounds open to heal by granulation instead of allowing them to repair by first intention. By all means allow Nature to heal by her own processes, but as soon as these show themselves insufficient to bring about a cure the surgeon ought to interfere, and the occurrence of cancer of the stomach will then become rarer instead of more frequent, as is the case at present. My treatment consists in resort to a good dentist, diet, and if necessary partial gastrectomy and gastro-enterostomy. It ought to be a reproach to doctor and patient alike to have a history of dyspepsia lasting for six, eight or ten years with intervals of improvement when the patient is put to bed, followed by renewed pain when she returns to her ordinary habits. It should, how-ever, be clearly understood that the surgeon cannot cure in every case, and that he must be guided by the signs and carefully weigh each history. The term "chronic gastric ulcer" is at the present time purely clinical, and very similar symptoms are presented by several different classes of gastric disease.

Officers of the Indian Medical Service on the active: list have subscribed a fund to found a prize in memory of the late Sir Joseph Fayrer, to be awarded at each half-yearly examination to the lieutenant on probation I.M.S. who obtains the highest number of marks in the subject of pathology at the conclusion of the course at the Royal Army Medical College. The prize will consist of a medal, with, in addition, a gift of books, should the proceeds of the fund permit. THE

### EARLY DIAGNOSIS OF CANCER OF THE STOMACH. (a)

BY ARTHUR F. HERTZ, M.A., M.D.Oxon., M.R.C.P.:

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I SHALL confine my remarks to two methods of diagnosis of cancer of the stomach, which have been comparatively recently introduced, and which promise to be of considerable value in aiding us to diagnose the condition in its earliest stages, when there is still a possibility of radical

cure by operation.

The first method is the examination of the stools for "occult blood." Hæmorrhage from a gastric growth is rarely sufficient to give rise to obvious melæna, and blood is visible in the vomit of less than 40 per cent. of cases kept under observation until the fatal termination. As in the majority of instances hæmorrhage severe enough to cause obvious hæmatemesis is a comparatively late symptom, and as its occurrence, even in the form of the so-called "coffeegrounds vomit," may with equal probability be a result of a simple gastric ulcer, the obvious presence of blood in the vomit or the stools is of very little help in the early diagnosis of cancer of the stomach. But minute hæmorrhages are constantly occurring from the surface of every malignant gastric ulcer, so that a small quantity of blood is constantly excreted in the fæces. This fact was first utilised as a means of diagnosis by Ewald, and numerous papers on the subject have since been published abroad, but, so far as I am aware, only one-by Dr. Leech, of Manchester-in England. Chemical tests for occult blood in the fæces are much more satisfactory than microscopical or spectroscopic: the best are the guaiacum and the benzidene reactions made with ethereal extracts of stools, which have first been treated with glacial acetic acid. The test is more satisfactory when applied to the stools than to the vomit, as it is necessary to make a series of examinations, and vomiting may not be of sufficiently regular occurrence for this to be possible. There is also no advantage to be gained by looking for occult blood in the gastric contents obtained by the passage of a tube, and it is undesirable to worry the patient by passing a tube more frequently than is absolutely necessary. The test for traces of blood in the fæces is so delicate that the small quantity present after meat has been eaten may give a positive reaction. It is therefore advisable to put the patient on to a farinaceous or milk diet for a few days prior to the first examination. This diet has an additional advantage, as it helps to distinguish between a malignant and a simple gastric ulcer. Slight oozing of blood frequently occurs from the surface of chronic non-malignant gastric ulcers; but with a non-irritating diet, the hæmorrhage quickly ceases, whereas in the case of a growth the hæmorrhage is quite unaffected. No less than 92 per cent. of 266 recorded cases of gastric carcinoma gave a positive reaction, although it was rare for the microscopic appearance of the stool to suggest that blood was present. The blood was found in all, or nearly all, of the specimens of fæces examined in each case. On

<sup>(</sup>a) Contribution to a discussion at the Harveian Society, March 4th, 1909. See page 301.

the other hand, in no single case of gastritis, nervous dyspepsia or pernicious anæmia, has the test for occult blood in the stools been positive. Apart from the occurrence of obvious hæmatemesis and melæna, traces of blood are frequently found with gastric and duodenal ulcer, but in a much smaller proportion of cases than with cancer; moreover, under dietetic treatment, the blood always disappears in two or three days if the ulcer is simple in nature, but never if it is malignant. Hence the constant presence of occult blood in the stools of a suspicious case is strong confirmatory evidence that cancer is present, and its constant absence is even stronger evidence against the diagnosis of a malignant ulcer. Of course many of the published cases were examined in the late stages of the disease. Perhaps Mr. Moynihan and other surgeons here this evening can tell us from their operative experience on very early cancer of the stomach, in what proportion of such cases ulceration is present, as it is only after ulceration has occurred that a positive reaction for occult blood can be expected. In the large number of cases of cancer, which are due to malignant changes occurring in a chronic ulcer, the test would certainly be positive from the first moment that the cancer begins to develop. When the growth forms independently of any previous gastric disease, some time must, of course elapse before ulceration occurs, but I think that in such cases it will be found that ulceration begins at a very early stage.

The second method of diagnosis to which I wish to refer is skiagraphy. Unfortunately the results obtained by the X-rays in the diagnosis of really early cases have, up to now, been of less value than might have been anticipated. Occasionally, however, a clue is given to the correct diagnosis at a very early stage before a tumour has become palpable, so that I am convinced that in every doubtful case an X-ray examination

should be made.

Skiagraphy has been chiefly employed with the object of finding the size of the stomach and the rate with which it gets rid of its contents, and thus obtaining evidence as to the existence of pyloric obstruction. My own experience, however, shows that, though the X-rays may give valuable help in other ways, they do not give as reliable information on these points as certain older methods of examination. In an investigation on the normal anatomy of the stomach, Dr. C. J. Morton and I found in seventeen normal young men remarkable differences in its size and shape. In the vertical position the greater curvature always reached below the umbilicus, the distance varying between 1 and 12 cms. Normal variations being so considerable it is impossible in the vertical position to recognise a slight dilitation by means of the X-rays. In the horizontal position, the bismuth tends to collect in the fundus, so that the position of the greater curvature is often difficult to ascertain. On the other hand, inflation of the stomach with carbon dioxide produced by the action of tartaric acid on sodium bicarbonate, the two substances being swallowed in water rapidly after each other, or with air introduced by a tube passed with the object of obtaining the remnants of a test-meal, gives constant results in normal individuals, the greater curvature being invariably on a level with, or slightly above, the umbilicus. Very slight dilatations are therefore readily recognised, as the

greater curvature reaches below the umbilicus. On rare occasions, moreover, the inflation may cause a tumour previously impalpable to become palpable. It very rarely causes any discomfort, and although the distension it produces is obviously not physiological, it gives definite results which can be compared with a definite normal standard. I may here mention that my X-ray investigations have shown conclusively that both direct percussion and auscultatory percussion are quite unreliable as means of determining the size of the stomach, except when it has been inflated with gas.

With regard to the rate at which the stomach empties it must be remembered that even if there is considerable obstruction to the pylorus, fluids, if given alone, can pass through it without much difficulty. Hence it is an error to assume that obstruction is absent if fluid, in which a bismuth salt is suspended, is seen to leave the stomach rapidly after its entry. For such examinations a proper bismuth meal, containing solids as well as fluids should be given. It has also been supposed that a shadow present in the region of the stomach six hours after a bismuth meal indicates that there is delay in the passage of food into the duodenum. But I am convinced that traces of bismuth may remain adherent to the gastric mucous membrane for a considerable period after all the food has left the stomach. In my opinion, therefore, no conclusion can be drawn from X-ray examinations as to delay in the evacuation of the gastric contents which can compare in reliability with the results obtained by passing a tube at 8 a.m. into the stomach of a patient whose last meal was dinner taken at 8 p.m. the previous evening. The presence of food residues in the stomach under such conditions is almost conclusive evidence of organic stricture of the pylorus, as it is exceedingly rare for an atonic stomach to be unable to empty itself completely in twelve hours.

.The value of X-ray examinations as an aid to the early diagnosis of cancer of the stomach, depends almost entirely on the opportunity they occasionally afford for direct observation of abnormalities in the shape and movements of the organ. The patient should take a pint of bread and milk containing two ounces of bismuth oxychloride instead of breakfast, and he should be watched in the vertical position with the screen whilst the first few mouthfuls are eaten, in case any delay occurs in the passage of food through the cardia, which would be suggestive of a growth in this situation, or any irregularity is noticed in the course taken by the food as it slowly passes towards the pylorus. When all the bread and milk has been taken the patient should lie for a minute on his right side, so that some of the bismuth may enter the pyloric vestibule, after which he should lie on his back during the screen examination. Occasionally an abnormality in the outline of the stomach is caused by the projection of a growth into the lumen. In other cases the pyloric vestibule cannot be seen whatever position is assumed, as a growth in this region may prevent the entry of more than a very small quantity of the gastric contents. Equally valuable evidence of the existence of a growth is obtained if an irregularity is seen in the passage of the peristaltic waves towards the pylorus. When the growth is in the pyloric vestibule the waves, which may be unusually

strong and frequent, often cease some distance from the pylorus, owing apparently to the growth interfering with the normal activity of the muscular coat of the stomach. It is advisable before concluding the examination to inject air into the colon; this pushes the stomach upwards, but at the same time it makes the outline of the greater curvature more definite, and occasionally makes it possible to recognise the presence of a tumour, which would otherwise have been missed.

# THE MEDICAL EXAMINATION OF SCHOOL CHILDREN. (a)

By GEORGE CARPENTER, M.D.,

Physician to the Queen's Hospital for Children, Vice-President of the Royal Society of Medicine, &c.

DR. CARPENTER said that the Board of Education, in its Circular numbered 582, dated January 23rd, 1908, addressed to local education authorities on the subject of medical inspection of school children, refrained from issuing a complete set of forms, thinking it expedient to leave considerable latitude in regard to the particular forms or schedules. A schedule of medical inspection, together with elaborate notes for inspecting officer, was, however, issued wherein the Board of Education indicate the particulars, attention to which they regard as constituting the minimum of efficient medical inspection. Dr. Carpenter expressed the opinion that the Board of Education, in refraining from issuing definite forms, intended to allow the local authorities to incur any odium attaching to this official work; in other words, the local medical inspector of the schools, who would perform the rôle of Jonah should a storm arise. The feelings or prejudices of parents have to be considered, according to the statement of the Board. These feelings and prejudices hamper the medical man in the performance of his duties, and mark him out for popular sacrifice, to escape which he was entitled to official sanctuary. The schedule of medical inspection set forth by the Board was impracticable and unpractical, and to make it workable a practical chinical chart had to be designed. Dr. Carpenter pointed out the far-reaching nature of the indications in the notes for inspecting officer accompanying the schedule of medical inspection, copies of which were provided at the meeting, and described how, to facilitate medical in-spection in a London suburb whose local education authorities had engaged him to examine some hundreds of their school children, he drew up a practical form comprising all the requirements contained in the Board of Education Circular (No. 582) to local education authorities. Dr. Carpenter's form was also placed in the hands of members of the section. Dr. Carpenter then described the method which he had adopted in inspecting the children. They were undressed, wrapped in a blanket, placed on a couch, and a thorough medical inspection was made in the best room that could be obtained at the particular school for the purpose. In many instances the parents were present, and in all cases one of the schoolmasters; or schoolmistresses. Dr. Carpenter then read extracts from the letters he had received objecting to the medical examination. The chief objection appeared to be that to the examination for the presence of adenoids, and one parent stated that the same rug or blanket in which the child was wrapped was usel for each and every child.

(a) Paper introducing discussion at the Rayal Society of Medicine Feb. 26th, 1999.

In response to the letter from the clerk of the local. Education authority in reference to parents' complaints, the Board of Education arranged for the representative of the local education authority toattend at the Board of Education to discuss the matter. Dr. Carpenter, however, not being notified. until the morning of the interview, was unable toattend. The Board of Education appeared to-consider that to undress children for the purpose of medical inspection was superfluous and unnecessary, and that the heart could be easily auscultated by exposing a small cutaneous area over the left nipple. The quaint instruction that a child could be pronounced healthy by looking at it was also upheld. Dr. Carpenter went on to say that it wasobvious that if the medical examiner did his duty and examined properly, if the parents objected, he need expect neither support nor encouragement from the local education authority, nor from the Board of Education. If, on the other hand, he did not perform his duties properly, his functions are parasitic rather than medical, and he becomes an extra and unnecessary burden on the rates and the taxpayer. What medical man is there who understands his profession, and who knows the business, who can pronounce by looking at a child whether it is healthy or not? If these be really the well-considered views of the Board of Education, then the sooner it is instructed by men whohave had clinical experience the better for the country. If we are to have medical inspection of elementary school children, let it not be a sham. The information demanded by the Board of Education in its Circular No. 582 could not be obtained by any such antiquated methods. Dr. Carpenter then read notes of the various deformities, defects, and diseases which he had found in his examination of 552 presumably healthy elementary school children of a London suburb, who were undressed and properly examined. Over 200 had. rickety deformities in varying degrees. In 367 the teeth were carious, with a total of 1,514 carious teeth, an average of 4 per girl and 4½ per boy-The tonsile were enlarged in 119, 129 there were adenoids, the naso-pharynx. in 34 being completely blocked by growth. In 181 the deep cervical glands were enlarged, in 172 the sub-maxillary, and in 337 the superficial cervical; 29 children had bronchitis, 1 pneumonia, and I cirrhosis of one lung with a transposed heart. This last child looked particularly well and had rosy cheeks, and under the quaint instructions of the Board of Education would have been excluded from any searching examination. Of skin complaints 2. had xerodermia, 1 psoriasis, and 7 pediculi corporis. These defects were discovered by examining their skins, and not by looking at their waistcoats and pinafores. To many examiners of school children who take a pride in their work, the class of men the Board of Education ought to enlist, it is a matter of vital interest to know how much support they will receive in their arduous duties from the people who have set them their task. If the Board of Education's "Notes for Inspecting Officer," the minimum of efficient medical inspection as laid down by the Board are not intended to be taken seriously, then let the Board modify or withdraw them, because as they stand they compel a conscientious medical inspector to make a thorough examination in every case. The legislature, when it ordered medical inspection, at the same time authorised attention to the health and physical condition of the children. Before there can be treatment there must be diagnosis, and diagnosismust be preceded by medical examination. present instructions to local education authorities. by the Board of Education on the way to conduct a medical inspection can only be viewed as an illadvised encouragement to medical inspectors of elementary school children to pocket the fees and neglect the work, and so rob the Act of most of its value.

### OPERATING THEATRES.

PADDINGTON GREEN CHILDREN'S HOSPITAL. EMPYÆMA WITH ABDOMINAL SYMPTOMS.--MR. ARTHUR EDMUNDS operated on a boy, set. 5, for a small left-sided empyzema. The boy had been sent in a week previously with a history of an acute onset of ab-dominal pain referred to the right iliac fossa. There had been vomiting on each of the days preceding his admission. The abdomen had been tender and rigid. On admission the child was found to have a temperature of 103°, and a pulse of 120. A diagnosis had been made of acute appendicitis. Although subsequent events proved that this diagnosis was inaccurate, Mr. Edmunds pointed out that there was much in the symptoms to suggest it—the acute onset, with symptoms of an acute infection, with vomiting and reference of pain to the right iliac fossa made up a picture which anyone might mistake for appendicitis.

Mr. Edmunds said that the first point noticed was that the respirations were out of all proportion to the temperature; they were 48; secondly, that the alæ nasi were acting very markedly. In all breathing, he remarked, there is the action of the ordinary respiratory muscles, but, in addition, there are associated movements of the alse nasi and larynx—that is to say, dilatation of the alse and rima glottidis, or abduction of the cords during inspiration and the reverse during expiration. These occur normally, but in some respiratory affections, especially when they involve an irritation of the parietal pleura, these are increased. The nasal movements are easily visible; the laryngeal are evidenced by a respiratory grunt, indicating the pas-sage from the stage in which the air is contained in the lungs under pressure from the contracting thorax to the stage when expiration takes place. When the child under consideration was quite quiet, respiration was without any noise, but directly the boy was moved about for examination, the expiratory grunt came on. In addition, the patient's facies did not suggest abdominal disease; there was entire absence of the anxious, haggard look, and sallow complexion these patients have, and the child was comparatively cheerful. On placing the hand on the abdomen, the whole abdomen felt rigid and board-like, but when the child was allowed to lie quietly in bed, the clothes pulled up over him, and the abdomen examined under the warm bed-clothes, gentle pressure soon revealed the fact that this rigidity was spurious. The abdomen could then be completely relaxed, and the whole of the iliac fossa explored. Careful questioning now elicited the fact that the child referred his pain to the umbilicus—in other words, his localisation was quite un-reliable. The alæ nasi and the respiratory condition generally suggested that a pulmonary affection might be at the root of the whole trouble. Careful examination of the lungs revealed an early pneumonia at the left base. The child was seen again the same evening in consultation with Dr. Leonard Guthrie, who was able to satisfy himself as to the definite nature of the pneumonia.

The relationship between abdominal symptoms and intra-thoracic disease should, Mr. Edmunds said, always be borne in mind. It may be dependent on one or two factors: In the first place, pulmonary affections may involve the diaphragm, in which case it is not difficult to see how the abdomen may seem to be largely involved; this is specially so when the pul-monary affection is confined to the portion of the lung which is actually in contact with the diaphragm; in fact, in these cases the pulmonary symptoms may be largely absent. In other cases the pulmonary affection may be only part of a general pneumococcic invasion, in which the peritoneum actually shares, but from which it rapidly recovers.

The pneumonia ran a normal course, but at the end of ten days fluid appeared at the left base, which on exploration turned out to be purulent. Accordingly, the child was anæsthetised, a rib resected, and drainage tube put in.

### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD FRIDAY, FEBRUARY 26TH, 1909.

Mr. SYDNEY STEPHENSON, F.R.C.S.Ed., in the Chair.

DR. HIGGS, on behalf of Dr. CAUTLEY, showed (1) a case of cerebral diplegic spasticity in a boy of six months, which came on with rigidity in the back and limbs, and retraction of the head, at the age of seven weeks. On admission to hospital three weeks ago, there was general rigidity, which varied from time to time, and would come on with spasms, with considerable crying. The boy improved on a mixture of bromide and chloral. Mr. Bishop Harman found the left disc unduly red, with a few pigment spots along the course of one vessel. The condition was ascribed to an attack of exceptability followed by corrected. to an attack of encephalitis, followed by cerebral! sclerosis of the motor region.

Mr. BISHOP HARMAN showed a sketch of the pigment

spots, which might be termed congenital warts.

(2) A boy, æt. 4½, suffering from abdominal tuberculosis. The abdomen was enlarged, with a band stretching across the upper part, giving the impression of a coiled-up and matted omentum, containing caseous matters. He had been treated with tuberculin. The opinion of members was asked on the advisability of attempting the removal of the caseous matter by surgical means, or on a continuance of the general

methods of treatment and larger doses of tuberculin.

Dr. Milner Burgess said that if the lungs were not

affected he would advise operation.

Dr. Higgs replied that, although there was no evidence of infection of the lungs, he thought the case should not be operated upon, as some of the masses-were probably due to inherent coils of intestine, and contained caseous glands. (3) A Mongolian imbecile, aged 7½ months. The case showed brachycephaly, a large fontanelle, palpebral apertures sloping upwards and outwards, inability to sit up, placidity and good nature.

Mr. Sydney Stephenson showed a child, æt. with a soft, doughy swelling situated over the right half of the vertical portion of the frontal bone, and extending into the right upper eyelid, and also into the temporal and parietal regions. It was adherent to the overlying skin, and a cord-like feeling can be made out in some parts of it. The child is said to have attended the Moorfields Hospital for buphthal mos, and was brought to hospital on January 21st with acute inflammatory cedema of the right upper eyelid. It was impossible to say for certain what the condition was, but he thought that it might be a plexiform neuroma, and hoped to excise a small portion of the tumour for microscopical examination.

Mr. W. M. Mollison (M.O.) showed a child, æt. 2,

Mr. W. M. Mollison (M.O.) showed a child, 2t. 2, with absent abdominal muscles. The abdomen was very pendulous, and the walls thin and lax, the abdominal walls being easily felt even when the child cried. The bowels kept regular, and there was no difficulty in micturition. No electrical response could be obtained from the abdominal wall. There did not appear to be any distension of the bladder or thickening of the ureters.

Dr. LANGMEAD said that there were about 18 cases on record. Usually there was much distension of the bladder and thickening of its walls, with palpable ureters. He believed that most of the cases had died in early infancy; the present one was an exception in that respect.

Mr. Lockhart Mummery showed (1) a child who had suffered from acute epiphysitis of the lower end of the femur at the age of 1 year and 7 months. After

operation the abscess cavity remained at the lower end of the diaphysis, which was scraped out, washed with strong formalin, and filled with sterilised paraffin wax, the wound being stitched up again. The general health of the patient was good, but a small sinus remained, from which a little clear fluid, and occasionally some of the wax, was discharged for about six months. It is now two years after the first operation, and there is no appreciable deformity of the bone or shortening of the limb, and X-ray photographs show that the cavity in the bone has almost disappeared. The incavity in the bone has almost disappeared. fection was a mixture of streptococci and staphylococci. (2) A case of talipes calcaneus treated by

splinting with a good result.

Dr. O. GRUNBAUM showed a case of Hirschsprung's disease, or chronic dilatation of the colon. A child, æt. 4, was admitted to hospital in August, 1908, for fits and constipation. The abdomen was enormously distended, the skin being tight, and the superficial veins prominent. On administering an enema an enormous result was obtained, and on repeating this at intervals the child returned to a normal condition. He has been re-admitted twice since with a similar condition. Improvement followed rapidly each time upon the administration of enemas. The risk of colectomy was so great that Dr. Grunbaum, having consulted with his surgical colleague, considered that so long as the child can be kept in a healthy condition with suitable treatment, no operation should be done.

Dr. G. A. SUTHERLAND said that all the cases he had seen had died. As the prognosis was so bad, and the patient was now in such a favourable condition,

it would be well to operate now.

Mr. LOCKHART MUMMERY said Dr. Sutherland spoke lightly of operation, but what operation should be done? The mortality of colectomy in a number of cases in this condition which he had collected was 75 per cent.; that was because one could not bring the bowel up and make a spur of the abdominal wall. All that could be done was to form a fæcal fistula at the dilated portion of the bowel, and in most cases the bowel had torn away from the abdominal wall and the patient had died of peritonitis. The only operation likely to give permanent results was the excision of the dilated portion of the colon. This was a serious proceeding, but, even if successful, the colon might become re-dilated. He quoted four cases in which this had occurred. In a case which had gone on to adult life, a man, æt. 23, he had done appendicostomy, the bowel being washed out daily. It was now six months since the operation, and the man had had no obstruction.

Dr. GEORGE CARPENTER opened a discussion on the MEDICAL EXAMINATION OF SCHOOL CHILDREN,

which will be found on page 208 of our present issue. Dr. Fremantle (M.O.H., Hertfordshire) said he approached the matter from a different standpoint to that of Dr. Carpenter. As County Medical Officer his work was to superintend the inspection of 47,000 school children in 33 sanitary districts. The work was actually done by medical practitioners who were engaged in clinical work, and were in touch with the conditions under which the children lived. The inspection was done three times during a school child's life. The Government in Britain went slowly, and the inspections might be more frequent later. reports were made on cards, 10 in. by 6 in., suitable for filing. The scheme drawn up by Dr. Carpenter for filing. The scheme drawn up by Dr. Carpenter could not be beaten for comprehensiveness, but, as a record, would not be worth having, unless the examiner were paid at least a guinea a child, to which he, as a ratepayer, would strongly object. That showed the fundamental difference between Dr. Carpenter's and his own points of view. The public were the ultimate masters, and the Government took the view that the matter must only be carried as far as the public wished. The point was to so carry out the inspection as not to arouse feelings which the inspector had no right to arouse. He thought the Circular 582 of the Board of Education was a masterly production. The remuneration was based upon an average rate of inspection of six per hour. Dr. Fremantle explained the system of marking the cards adopted in Hertford-

shire. He did not think the Section for the Study of Disease in Children ought to expect a large\_series of valuable statistics from the inspection. The main object of the inspection was the individual one. The Education Department wanted inspection, not examination. The object was not to detect the one in a thousand defective.

Mr. N. BISHOP HARMAN said that when he looked through Dr. Carpenter's schedule he felt admiration for Dr. Carpenter's energy, and thankfulness that he was no longer a school doctor. He doubted the capacity of a Medical Officer to fill up Dr. Carpenter's schedule. The object of the school inspection was to treat the diseases of children. Dr. Carpenter's mis-directed energy was due to the fact that he had spent a good deal of his life in the wards and out-patient departments of a children's hospital, where the children were necessarily diseased, and that fact of disease had become an obsession. The person of most use to the Medical Inspector was the teacher. What was chiefly wanted was a place to send children to as soon as it was discovered that they had something wrong with them. The object was not to find out what proportion of children had displaced hearts, nor what was the size of the inguinal rings. He believed the cry of degeneration was an extremist one.

Dr. G. E. SHUTTLEWORTH said his experience had been exclusively with children suffering from mental It was not easy to make up one's mind as to a child being healthy without going into some detailed examination. It was most important to decide whether the heart was sound, especially in view of the school drill and some drills in particular. He did not agree that the teacher could always give information as regards the hearing and sight. He had found children among the dullards at the back of the class who had been put there because they were considered below the standard, but who were found to be alert, though deaf, and should have been placed in front, where they could hear the teacher's voice. The same was true of defects of vision, and on those points there should be a systematic examination of every child in a school. One speaker well said that the whole question was the finding out of what children good could be done to. But what good could be done to children whose parents would not listen to the warnings of the medical inspector? There had been, apparently, some difficulty in conveying that warning without giving offence to the medical practitioner, but he hoped those matters would be adjusted in the course of time. If any medical inspector could do justice to the 24 questions on the Board of Education schedule with the marginal notes in ten minutes, he must be an extra-ordinary person. A good plan was to only examine a certain number at each visit.

Dr. W. EWART said that it stood to sense that mere inspection of a child could not give any idea of the state of its inside. By paying careful attention to the early stages and probabilities of tuberculosis, very much could be done towards preventing that disease.

Dr. Dan. McKenzie said no doubt all present would feel some sympathy with both the views which had been brought forward. For any benefit to be derived from medical examination it must be thorough. he believed it would be a long time before parents would submit their children to a proper examination, and the Board of Education document was as much as one could expect at present. He believed, how-ever, that Dr. Carpenter's speech would hasten a more perfect system. School *cliniques* in many parts of the country have much to recommend them, but in London and other large cities, containing many suitable institutions, they would be but waste of energy and time. There was only one way of examining for adenoids, namely, by putting the finger into the naso-pharynx. It was disagreeable and painful, and was sure to raise opposition. But the teacher would soon be able to report suspicious subjects of adenoids, and only a certain proportion of children would examined for them. The throat could be examined without pain.

Mr. Rose said that dental caries was very prevalent, 85 per cent. to 90 per cent. being subject to it. As dental surgeon the work of inspecting the mouth was not difficult. The requirements as to stopping or extraction should be carefully noted. Syphilitic teeth were not important in that connection because they

could not be treated.
Dr. CARPENTER briefly replied. He said Mr. Harman seemed to think that one could find out what was the matter with a child by looking at its waistcoat. He hoped Mr. Harman did not carry out this idea when examining eyes. His own schedule did exactly what the Board of Education required. The Examiner had only to "yes" or "no" under the various heads. After 20 years' experience, he declared he could not say whether a child was ill by looking at it as required by the order. What had brought about the present storm in a teacure was the brought about the present storm in a teacup was the digital examination of the naso-pharynx; it was not the undressing. Yet it must be fully realised what an avenue the tonsils were for various systemic diseases, and that it was not uncommon to have the cervical glands tuberculous from adenoids or enlarged tonsils. He was not putting himself in opposition to the Board of Education, but was supporting the examining medical men. His statistics bore out the impression that there was much rickets and general disease in the suburbs, and a good deal of it could be prevented through the Public Health Department.

### ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, MARCH 5TH, 1909.

The President, Dr. E. H. TWEEDY, in the Chair.

#### FIBRO-CYSTIC MYOMATOUS UTERUS.

DR. ALFRED SMITH exhibited a large fibro-cystic myomatous uterus taken from a patient, æt. 38, who informed him that she never felt any inconvenience up to some months before her admission to hospital, when she noticed she was getting rather stout. She was sent to him with a provisional diagnosis of ovarian cyst, and the clinical features were identical with the phenomena obtained in that condition. On opening the abdomen he thought he had to deal with an ovarian cyst, but to his astonishment he found a fibro-myoma which had undergone the degeneration seen in the specimen, giving a uniform pearly whiteness.

The PRESIDENT said the specimen illustrated the difficulty of gynæcological diagnosis. A big fibrocystic tumour was indistinguishable from ovarian cyst in a great number of cases. In examining per the rectum they could occasionally feel an ovarian pedicle, and if it was absolutely distinguished the diagnosis of ovarian cyst was made, but the absence was no proof

that they were not dealing with an ovarian cyst.

Dr. Smith, in reply, said he did not make any rectal examination, as the case seemed perfectly simple and straightforward.

UTERUS WITH LARGE CYST OF GAERTNER'S DUCT ATTACHED.

Dr. ALFRED SMITH exhibited also a uterus with large cyst of Gaertner's duct attached. Twelve years previously he removed what was called an ovarian cystoma from the other side of the patient. She afterwards complained of another enlargement. He opened to remove the cyst, and found that when he was dissecting it from the broad ligament it seemed to extend right down into the vagina. When he separated it as far as he could he found that the uterus had no support, and he removed it along with the cyst.

The PRESIDENT said he had operated on similar tumours, and had the greatest difficulty in enucleating them, as they not only went deeply into the pelvis and vagina, but climbed up under the peritoneum.

OBSTETRICAL AND GYNÆCOLOGICAL REPORTS OF THE ROTUNDA HOSPITAL.

The PRESIDENT read the obstetrical and gynæcological reports of the Rotunda Hospital.

On the proposal of Dr. ALFRED SMITH, seconded by Dr. NEILL, the discussion of the report was postponed till next meeting of the Section.

### HARVEIAN SOCIETY OF LONDON.

MEETING HELD (IN THE STAFFORD ROOMS) MARCH 4TH, 1969.

The President, Dr. CHARLES BUTTON, in the Chair.

A DISCUSSION ON THE EARLY DIAGNOSIS AND TREATMENT OF CANCER OF THE STOMACH.

Dr. HALE WHITE, who opened the discussion, said that one-half of all cases of cancer, as observed in the post-mortem room, commence in the stomach, and that one-fifth of all deaths in hospital die of cancer of the stomach. The cure must be surgical. To render this possible, an early diagnosis is imperative. The patient's history is of the greatest importance. Threefourths of all cases occur between 40 and 70. If symptoms of gastric indigestion first appear after 40, and if those symptoms are unaffected by ordinary medical treatment after 3 to 4 weeks, organic disease should be strongly suspected, and the abdomen should be opened. Nine per cent. of cancers, as observed post-mortem, grow from previous simple ulcers; but this figure is probably fallacious, because the carcinomatous growth may completely efface a previous ulcer. Dr. W. J. Mayo has observed about half of the cases of cancer, treated by operation, arising from simple ulceration. The history of previous ulcer may be fallacious, for the symptoms may be due to a non-ulcerous condition. An early diagnosis may be impossible, for the patient may first seek advice from enlargements due to secondary growths; this is not uncommon in secondary carcinoma of the liver. The commonest symptoms are as follows: Pain, present in 90 per cent. of all cases, is usually constant, and not related to food. Weakness is quickly experienced, and is more profound than in simple dyspepsia. Loss of appetite is a striking feature in carcinoma, but not in dyspepsia. Nausea occurs early. Free hydro-chloric acid is diminished in many cases of carcinoma of the stomach. In 10 per cent. of cases it is increased. This is said to occur especially in cases where the carcinoma has developed on the site of a previous-ulcer. The objection that the free hydrochloric acid is diminished by a carcinoma occurring anywhere in the body is unimportant, because malignant disease elsewhere is easily recognised by ordinary physical signs. Cases of atrophy of the gastric nucous membrane, and chronic gastritis, may diminish the free hydrochloric acid, but the diminution in these cases is less marked than in carcinoma. The presence of cancer cells or blood cells should be sought for in centrifugised washings of the stomach. In 35 to 40 per cent. of cases of carcinoma, the vomit at some time or another contains blood visible to the naked eye. In 60 per cent. of cases the growth occurs at the pylorus, and causes obstruction of the pylorus and dilatation of the stomach. Percussion without artificial distension and percussion are fallacious as signs, but examination with the X-rays with a screen, after a bismuth meal, is very useful. Delay in the passage of the bismuth through the pylorus can be seen; but the position of the bismuth shadow is not important, because the position of the stomach is very variable. Visible peristaltic contractions are valuable evidence of pyloric obstruction. No medical treatment can cure gastric carcinoma, hence the necessity for an early diagnosis, by which the surgeon can remove the growth. Before surgical treatment, the liver and left supra-clavicular glands should be examined for secondary growths. Even if the growth cannot be removed, much

relief can be given the patient by a gastro-enterostomy.

Mr. MOYNIHAN said that cases of cancer of the stomach, when examined in regard to their previous history, may be divided into three groups:—(a) Cases, generally acute, in which the symptoms appear sud-denly and progress rapidly; the whole history may be confined within a space of 4 to 9 months. (b) Cases in which there is a history of one ancient attack, or of repeated attacks, due undoubtedly to the presence of a chronic gastric ulcer. (c) Cases in which there is no previous history of gastric ulcer; in some of these a condition of "ulcus carcinomatosum" may be found. The acute cases are not seldom ushered in by an attack

of severe hæmatemesis, with or without melæna. It is possible that such copious bleeding is dependent upon multiple hæmorrhagic erosions. The importance upon multiple hæmorrhagic erosions. The importance of a history of repeated attacks of indigestion, alike in their origin, course, and termination, cannot be exaggerated. Such attacks are due to a chronic gastric ulcer, which at last becomes malignant. Cancer of the stomach, in so far as it depends upon a chronic ulcer for its origin, is a preventable disorder. It is probable that two-thirds of the whole number of cases may be so classed. The final attack is distinguished from former attacks by its lingering character, its rebellion against the treatment, dietetic and medicinal, which has proved helpful before, but chiefly by the presence of a profound distaste for food, anæmia, and a progressive loss of weight. The chemical examination of stomach contents is of little or no value in so far as early diagnosis of carcinoma of the stomach is concerned. In the later cases, when a pos-sible diagnosis of malignancy is made on the clinical evidence, the results of repeated chemical analyses of the stomach contents afford additional evidence of considerable value. Surgical treatment should be advised in all cases of stomach disorder where there is obstruction, stasis, or tumour, and in all cases of chronic ulcer; in this way early cases of carcinoma will be discovered, and radical treatment will surely be possible. There are no symptoms, and there are no signs, which individually or collectively permit of an assured diagnosis of cancer of the stomach in an early stage. In cases where there is grave suspicion an exploratory operation should be advised. Such operations should be practised to enable a diagnosis to be made in an early stage, not to confirm an almost certain diagnosis in a hopeless stage.

Dr. ROLLESTON said that it was obvious that under malignant disease of the stomach very different pathological and clinical conditions were included. the rare cases of the diffuse lympho-sarcoma of the stomach described by Salaman and others, in which the growth extended like a sheath along the alimentary canal, was a special form of new growth, possibly of infective origin, and from its method of spreading obviously unsuited for the radical treatment by excision, which, after all, was the important question for discussion. The more ordinary forms of malignant disease of the stomach fell into two main groups, which differed entirely, both in their clinical symptoms and as regards the possibility of cure by operation. These two groups were:—(1) Carcinoma of the cardiac end, and carcinoma of the pylorus; as a sub-division of this group the cases of carcinoma spreading from the pylorus and lesser curvature to the body of the stomach, and producing the leather-bottle stomach, might be included. In malignant disease of the cardiac end the symptoms were constitutional—namely, fever, anæmia, and debility, and might suggest tuberculosis, or infective endocarditis; whereas in carcinoma of the pylorus the symptoms localised the lesion to the stomach and commonly gave rise to mechanical effects. In carcinoma of the cardiac end the growth was rapid, was prone to necrose, to invade the adjacent left lobe of the liver, and set up diffuse suppuration in the adherent liver, and so to produce a condition most unsuitable for operative measures. He quoted cases of carcinoma of the cardiac end of the stomach resembling pulmonary tuberculosis; one patient with fever and intestinal hæmorrhage brought up material containing acid-fast bacilli, but the necropsy revealed a gan-grenous carcinoma containing acid-fast bacilli and no tuberculosis. The growth was so situated as to prevent any vomiting. In another case a gangrenous carcinoma produced a subphrenic abscess which in turn led to a left pleural effusion, which was the most obvious feature during life. In a woman admitted for anæmia and a tumour thought to be an enlarged spleen, skiagraphy, in the hands of Dr. Allpress Simmons, showed that the tumour was the stomach, with very thick walls, and a cavity 3 in. long by 1 in. broad. In cases of carcinoma of the pyloric end, it was important to make a diagnosis before a tumour was palpable, as in many instances metastasis had already occurred by the time that a tumour was manifest. In cases of prolonged gastric ulcer the tentative diagnosis was more easily made, even before the stage of tumour, by the absence of hydrochloric acid from the gastric juice, than in cases without any history of ulcer. In a patient with symptoms strongly suggesting gastric carcinoma, in whom a test meal showed an absence of hydrochloric acid in the gastric juice, exploratory laparotomy was justified to settle the question in the absence of tumour. When such an exploratory operation was undertaken, it was important that the surgeon should, in the event of carcinoma being found without obvious metastasis, proceed to partial excision of the stomach, and not lest content with gastro-enterostomy, which was a purely palliative course.

Mr. V. WAREEN LOW remarked that he came to the

meeting, not with the intention of making any contribution to the discussion, but in the hope of learning, and had not been disappointed. He had learned many things, but he certainly had not learnt how to make an early diagnosis of cancer of the stomach. As far as he could gather from the remarks of the openers of the discussion, Dr. Hale White appeared to rely chiefly on a careful analysis of the symptoms, such as pain, increasing ill-health, etc. No doubt, in the hands of such an experienced and careful observer as Dr. Hale White, this method, utilised in a large number of cases, would probably lead to a fair percentage of success, but he (the speaker) was afraid it would leave a considerable degree of uncertainty in the individual case, and particularly in that class of case so well described by Mr. Moynihan, in which the patient had suffered from stomach symptoms all his life. On the other hand, Mr. Moynihan apparently made the diag-nosis in the laboratory some days after the removal of a large portion of the patient's stomach. From the surgeon's point of view, or that of the mere seeker after truth, there could be no question that this was the best method. Whether it was so also from the patient's point of view was open to question. Partial gastrectomy, even in Mr. Moynihan's experienced hands, gave a mortality of 5 per cent. Gastro-enterostomy for simple ulcer had practically no mortality even in the hands of surgeons, who were practically tyros in stomach surgery. It was in everyone's knowledge that constantly cases occurred where even the most experienced surgeons had been deceived at an operation by the similarity of an old ulcer to a malignant growth. Dr. Rolleston had already mentioned such a case, and he (the speaker) recollected an instance where, in 1898, an anterior gastro-enterostomy was performed at St. Mary's for what appeared to everyone to have been a hopeless case of stomach cancer. This patient was alive and well two or three years ago. What would have been his chances had the operation been a partial The speaker was disappointed to find gastrectomy? that so little reliance was placed by gentlemen of such experience in gastric diagnosis on the chemical analysis of the contents of the stomach. As far as the speaker's own experience had gone, he had learnt to rely very largely on the expert examination of the stomach con-tents. His own cases had been examined for him by Dr. Willcox, and in the later cases, extending over a period of more than a year, this method in Dr. Willcox's hands had rarely failed him. He did not wish to say more, because he should like to hear what Dr. Willcox himself had to say on the subject. He concluded by thanking the openers of the discussion for their very interesting papers on this most

important subject.

Mr. T. Crisp English said that the important early signs of cancer of the stomach should be given a more prominent place in text-books on medicine and surgery. Too much space was usually devoted to the "classical" signs, and patients suffering from the classical signs were usually in a hopeless condition. He referred to the difficulty which sometimes occurs during an operation in diagnosing a chronic ulcer from cancer, even after careful inspection through an opening in the stomach. If the possibility of a radical operation arises, the diagnosis must first be certain. His own practice in such cases had been to excise a portion of the diseased area for microscopical examination, and then to do a gastro-jejunostomy; if the excised portion proved malignant, a partial gastrectomy was performed later. He fully agreed with Dr.

Rolleston's remarks as to radical operations, and he urged the more frequent performance of partial gastrectomy in preference to the palliative operation of gastrojejunostomy.

THE OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD IN THE ROOMS OF THE MEDICAL SOCIETY OF LONDON ON THURSDAY, MARCH 11TH, 1909.

The Vice-President, Mr. W. H. H. JESSOP, F.R.C.S., in the Chair.

DR. G. CARPENTER showed a post-mortem specimen illustrating oxycephaly, and Mr. Sydney Stephenson mentioned a similar case which he had had, commenting on the shallow orbit and the consequent ease of dislocation of the eyeball.

Mr. J. Rowan showed some fine stereoscopic colour photographs, by the Lumière process, of eye con-

Dr. EDRIDGE-GREEN exhibited a new form of lantern

for the detection of detects of colour vision.

Mr. Parsons showed a case of unilateral optic neuritis with white spots in the retina; and it provoked a long discussion, in which the Chairman, Mr. Nettleship, Dr. F. E. Batten, and Mr. Bishop Harman

Mr. JESSOP showed a case of keratitis punctata, with

a history of erythema nodosum.

Mr. MAYOU and Dr. L. GUTHRIE showed a case of optic atrophy (retro-bulbar) with cerebellar symptoms in a child.

Mr. E. TREACHER COLLINS read a paper on

CONGENITAL ANTERIOR STAPHYLOMA.

The author described the case of a child born with an opaque, vascular, staphylomatous cornea, who never had any discharge from the eye. When 15 months old he performed a Mules' evisceration upon it, and subsequently made a pathological examination of the elliptical piece removed from the front of the eye. It was found that Descemet's membrane and the ligamentum pectinatum were absent, there was no stroma to the iris, and the lens was also malformed. Most cases of congenital anterior staphyloma have been attributed to intra-uterine ulceration. Mr. Collins thought that a case in which there was complete absence of Descemet's membrane and the ligamentum pectinatum could not be accounted for by ulceration, and must be attributed to some developmental defect. He suggested that there had been a failure in the differentiation of the mesoblast which intrudes between the lens vesicle and the surface epiblast, into its several layers. Normally there developed from it the substantia propria of the cornea, Descemet's membrane, its lining endothelium, and the antero-fibrovascular sheath of the lens. From this latter the feetal lens largely received its nutrient supply and the stroma of the iris was to a great extent formed.

A failure in the differentiation of the several structures, or atypical development of the intruding mesoblast, might, as in the case under consideration, lead to a vascularised, thickened, fibrous mass, in place of the substantia propria, an absence of Descemet's membrane, of the stroma of the iris, and a malformed lens. He concluded by referring to several other congenitally malformed eyes, in which he had found defects in development of Descemet's membrane or the ligamentum pectinatum of a less extensive character.

The paper was discussed by Mr. Parsons and Mr. G. Coats, who failed to agree with all that Mr. Collins

had advanced.

Mr. E. NETTLESHIP contributed seven new pedigrees of hereditary cataract: (1) Twenty-four cases of lamellar cataract in four generations; (2) and (3) coraliform cataract, one of them containing 20 cases, in four generations; (4) (5) (6) and (7) pedigrees of senile and presentle (or juvenile) cataract in from two to four generations, some of them illustrating "anticipation," i.e., the occurrence of disease at an earlier age in the younger generation. Two of the pedigrees showed the introduction of a second heritable disease from an outside non-cataractous stock, goftre in one instance, insanity in the other.

Dr. F. W. EDRIDGE-GREEN and Mr. C. DEVEREUX MARSHALL submitted a paper on SO-CALLED ARTIFICIALLY PRODUCED TEMPORARY COLOUR-BLINDNESS.

They stated that Professor Burch, of Oxford, had read a paper before the Royal Society, which was published in the "Philosophical Transactions" in 1898, giving the results of his experiments, in which he split up direct solar light with a spectroscope, and then collected the rays of the individual colours with a convex lens, and saturated his own eye with any deconvex lens, and saturated his own eye with any desired colour. He then examined a spectroscope illuminated with diffuse daylight, and stated his results. He found that he could produce temporary colour-blindness to any colour in this way. His most important point was that by saturation with light at the "D" line, red and green blindness supervened, and these colours could not be perceived, and this he held to support the complex nature of yellow light, the Young-Helmholtz theory of colour-perception. Messrs. Edridge-Green and Marshall criticised his experiments. They thought that if direct sunlight were focussed in the retina, not only temporary, but probably perma-nent blindness might be produced, and, anyhow, the eye would be incapable, after much treatment, of making accurate observations on a feebly-illuminated They produced fatigue in their own eyes with a sodium light, and then found that yellow and orange became obliterated, and that red and green met in the spectrum, and that there was no diminution of those two colours. Other experiments were repeated with different colours, and in most of them they disagreed with Professor Burch's results, which, they held, were due to faulty methods of conducting the experiments. These facts are, they contend, only explicable on the psycophysical theory of colour vision (Edridge-Green's theory).

### CORRESPONDENCE.

#### From our special correspondents ABROAD.

GERMANY. Berlin, March 21st, 1909

At the Verein für Innere Medizin Hr. F. M. Groedel (Bad-Nauheim), spoke on Röntgen cinematography (with demonstrations) and its importance in internal medicine. He said that the involuntary movements of internal organs could not be shown by ordinary X-ray illumination, as the eye could not follow the rapid movements. An attempt had been made to remedy this by giving the combined movements. But this method could be looked upon only as a pis aller, as only a voluntary combination could be given. We first succeeded in giving good Röntgen given. We first succeeded in giving sood according illustrations when we were in a position to reduce the time of taking to the fraction of a second. The speaker had succeeded in getting an apparatus constructed which could be brought to the body within a few seconds, whilst at every change the Röntgen light could be shut off. By this means he was able to take all internal movements correctly, those of the heart, the stomach during digestion, and the diaphragm. It was also possible to demonstrate pathological internal movements in the same manner. (The movements of the heart and diaphragm were now shown on the screen.)

Hr. Levy Dorn said he believed he was the first to make cinematographic illustrations of the human sub-The cinematogrammes introduced by Macintyre in 1806 were only of small objects (the frog's thigh). After Macintyre, other similar Röntgenogrammes were shown, for instance, the movements of the frog's stomach.

The first attempts to demonstrate human organs cinematographically consisted in trying to take the fluorescent images with the ordinary cinematograph. This led, however, to no useful result. It was therefore something new when he Röntgenographed human organs in their individual movements. The representation of movement was only one object of cinematography. Such a thing was very instructive for the

thorax and other parts of the body.

Hr. Kraus said that Groedel had done good service by his labours, but that the cardiac movements were rather indistinct.

At the Medical Society Hr. Wolff made a short communication on the importance of Non-tuberculous Dulness of the Apex of the Lung as shown in the case of a young man. The patient had atelectasis of the apex, with occasional bronchial breathing; that this was only transient was shown by the further course of the case, as well as by the negative result of subcutaneous injection of tuberculin, and of ophthalmic reaction. It was not an individual case, 7 per cent. of those who were in health resorts in whom an affection of the apex was present on their admission proved to be non-tuberculous. By the combination of clinical and biological methods of examination he hoped that our diagnosis would be still further improved.

Hr. Abel said that he had examined all cases of CARCINOMA

microscopically, and had found certain structures in carcinoma of various organs to which he believed he must now give publicity. They were stratified capsules with cellular contents arranged in heaps, which, after bursting of the capsule, could pass into the surrounding tissues. He considered these structures to be of a foreign nature, but he would not express any opinion as to their character or ætiological signifi-

cance.

Hr. Waldeyer said that he had "controlled" the preparations; he also believed them to be of a foreign nature, but could not give any explanation as to what they were. That they were exciters of carcinoma was more than questionable, they might just as well be saprophytes.

Hr. v. Hansemann had known the structures for a long time. They were products of the change that took place in the cells attacked. In carcinoma there were pluripolar cell divisions, so-called "Verklumpte" mitosa, which passed out of the cells. These apparent capsules, which the speaker had called "division spaces," were an apparent granulated fringe of protoplasm, whilst the internal protoplasm was homo-

Hr. C. Benda did not look on the structures as foreign, and had found exactly similar ones in normal genital glands of amphibia. He agreed in the opinion of the last speaker.

Hr. Waldeyer acknowledged the value of the objections that had been raised, and

Hr. Abel stuck to his own views.

AUSTRIA. Vienna, March 21't, 1909.

SIXTEENTH INTERNATIONAL CONGRESS.
THE committee have now fixed the date of meeting this year in Budapest, commencing on the 29th of August and ending on the 4th of September. The members fee is 25 kronen, and the Secretary's address is Budapest, VIII. Esterhazygasse 7, with whom all papers have to be lodged on or before the 30th of

COXA VARA. At the Gesellschaft Lorenz presented a patient he had treated by the bloodless method for coxa vara in a very bad form. This patient was now free from defect, either functionally or anatomically. Hitherto, he said, this disease was treated surgically by opening the part which exposed the patient to danger with frequently very unsatisfactory results. The methods followed might be roughly divided into two forms:—First, resection of the dislocated head, neck, and all down to the great trochanter or the simpler operation of removing the acetabulum; second, the orthopædic method which consisted in correcting the direction of the femur, either by intra-articular or pararticular interference, or the wedge form osteotomy. As a rule all intra-articular operations were unsatisfactory as life was endangered, 7 per cent. dying, or later contractions invariably resulting. The extra articular was not so dangerous, but could only be recognised as a palliative or compensatory correction for the deformity. The blood-

less treatment owes its origin to the fact that recent fractures heal quicker and better than old fractures. It is therefore necessary to produce the same condition by "re-infraction" reposition, and subsequent by "re-infraction" reposition, and subsequent retention of the fragments in the proper place. With the assistance of radiography this replacement is now easy, and the danger reduced to a minimum while the useful function of the limb is obtained.

Frisch thought this interesting method of treating coxa vara could only be very limited in its applica-tion as it would depend largely on the site of the deformity. Very few of these occur about the proximal end of the neck of the femur where this method would be the most serviceable; if occurring in the upper third of the femur, or if the curve had a wider extent he could not see where any advantage could be obtained by this method.

Ewald was of opinion that this bloodless method

could only be applied in the case of children, as adults would be too resisting, while the adductors and extensors would be apt to undo all that had been done. He thought Lorenz might have given them a more complete explanation of the technique of his method

when they could have better judged of its uses.

Lorenz said his method of treatment was the same in principle he fully described 18 years ago for angular fractures in the upper third of the femur, where the distal fragment must be brought into apposition to the proximal.

TUMOURS IN THE HYPOPHYSIS.

Eiselsberg, who is making a special study of this part of the body, showed two of his latest cases where he had operated with perfect success. The first of the two was a young girl, et. 16, who suffered from the "infantile habitus," fatty degeneration, hemiopia, and great reduction of vision. The subjective symptoms were principally represented by intolerable pains in the head. The Rontgen rays revealed a distinct enlargement of the hypophysis.

The operation revealed a large cyst of a chocolate brown colour, containing the same coloured fluid. The wound was closed and healed by first intention, but after eight days ominous symptoms appeared, necessitating a re-opening, when, behind the frontal sinus, the dura was found to be inflamed with dangerous symptoms of meningitis, which dispelled all hope of symptoms of meningitis, which disperses an arrection recovery. Two days later lumbar puncture was perwas examined at the institute, and large pus cells with bacteria were found to be present, which led to the belief in a streptococci infection. Subcutaneous in-jections of Paltauf's streptococcus serum, with intravenous injections of electrargol, were administered. During this treatment cultures of the spinal fluid had been made, with the result that no streptococci were present. The bacillus found belonged to the type of microbes known as bacillus fæcalis alcaligenes. This explained why the spinal liquor cleared up in a few days after, when another puncture was made. Gradually the patient recovered from the meningitis, and now, two months after the operation, is perfectly well. The headache has quite disappeared, the vision is improved, and since leaving hospital her mother tells me the girl has menstruated once.

The second case was that of a male, æt. 36, who was void of libido sexualis, suffered from bi-temporal hemianopsia, atrophy of both optic nerves, and severe pain in the head. The patient had been sent from Fuchs' Clinic for observation and operation. The operation revealed a large neoplasm, and, when examined, was found to be a malignant epithelioma, The post-operative temperature was favourable, and the wound healed by first intenton. The somnolent condition of the patient necessitated a longer time than usual in bed, as fears were entertained that an abscess was forming in the brain. Happily these fears are now dispelled, as the patient feels fresher and stronger than ever he was, and has also a normal appearance. The pain in the head has quite disappeared, and the

vision is greatly improved. The most important point to observe in the operation of the hypophysis is to keep strictly to the nasal line to avoid both optic nerves, as any deviation from the middle line may do irreparable damage.

### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### EDINBURGH.

JUBILEE OF THE ROYAL HOSPITAL FOR SICK CHIDREN, EDINBURGH.

THE annual meeting of contributors to the hospital, held on March 17th, was of more than usual interest, because it marked the completion of the first half-century of the hospital's existence. Mr. James Clark, Chairman of the Directors, after alluding to the past year's work, said that the history of the institution during these 50 years had been one of unchecked progress. In 1859 a gentleman, Dr. John Smith, who was with them at the meeting to-day, started the movement by writing a letter to the *Scotsman*, over the signature of "Sigma," and that letter was the seed corn from which the institution arose. The suggestion was well received, and was clinched by another letter, signed "Merchant," which had a strong effect in bringing together and encouraging those who had resolved to found a children's hospital. The writer of that letter found a children's hospital. The writer of that letter, Mr. George Barclay, was also present that day. In the beginning £2,000 was gathered, and a house was purchased in Lauriston Lane, whence the hospital was transferred to Meadowside House, and subsequently to the present building, which cost £52,000, and was opened in 1895. Meanwhile, they had also accumulated funds amounting to nearly £50,000. This being their Jubilee, the directors thought it was a fitting occasion to make a step in advance by nominating two ladies as members of the Board of Management-Mrs. Wauchope and Mrs. Maconochie. In moving the customary resolution commending the hospital to the liberality of the public. Lord Salvesen pointed to two practical considerations: the first was that the Institution necessarily prevented a great waste of life; the second, that it set free for labour a great part of the community which, but for its existence, would have to devote themselves to the care of sick children. Lord Salvesen also spoke of the educational value of the hospital, and argued that the whole community benefited, indirectly at least, from the special skill which the physicians to the hospital acquired. Dr. Allan Jamieson, President of the Royal College of Physicians, seconded the resolution, and dwelt on the origin of hospitals in the Holy City of Jerusalem through the action of the Order of St. John. A phase of hospitalism not sufficiently insisted on, but which had great claims on the Christian public, was the educative moral effect exercised on the patients.

The speeches of Dr. John Smith and Mr. George Barclay, the venerable founders of the hospital, were listened to by the audience with close attention. Smith said that even in its embryonic stage the hospital got more substantial assistance than names to back it, for immediately after the letter signed "Sigma," Mr. George Barclay came forward with a gift of £100. It seemed at the time unaccountable that while so many hospitals for children existed throughout Europe, Edinburgh, so well known as a medical centre for any wears should have no institumedical centre for 300 years, should have no institu-tion of the kind. No doubt the matter had been discussed in professional circles, but public interest was never enlisted. Institutions of this kind were not merely benevolent; they were educational. Even in his student days he had perceived the importance of student days he had perceived the importance of studying in a hospital specially adapted for children, and this idea was confirmed by the insight gained when, in the stormy days of 1846—49, he, with his friend, Sir Henry Littlejohn, attended the Hôpital des Enfants Malades in Paris. He had only to add that in starting the scheme he had the assistance of his led fallow that of the leading members of the proin starting the scheme he had the assistance of his old fellow student, of the leading members of the profession, of the powerful Scotsman newspaper and its proprietor, Mr. J. R. Findlay, and of their late devoted Secretary, Mr. John Henry.

Mr. George Barclay concluded a short speech by saying that at the close of an exceptionally long life

it was a pleasure to look back on one good work at least in which he had helped. The older men might well be satisfied to hand on the burden of management to the younger and more active of to-day, who would carry on the good work in which they were all so

deeply interested, and which he was sure also was a blessing to the community.

### BELFAST

QUEEN'S UNIVERSITY, BELFAST.—ANNUAL STUDENTS' DINNER.—The annual dinner organised by the students at Queen's College was held on St. Patrick's Day, and was an occasion of special interest, as it was the first dinner of the new University. The Chancellor, the Right Hon. the Earl of Shaftesbury, presided, and over 100 were present, including many ladies. The speakers included the Chancellor, the Vice-Chancellor (President Hamilton), Sir Wm. Whitla, Professor Lindsay, Professor Symmers, Captain Cunningham, F.R.C.S.I., and others. The various speakers dwelt specially upon the happy ausnices for the future success of the Histories which are observed on all cess of the University, which are observed on all hands, and on the splendid opening for good work which lies before those connected with it. The undenominational and free character of the University was emphasised by more than one speaker.

THE MEDICAL CURRICULUM OF THE NEW UNIVERSITY. Great interest attaches to the rumours which are current in Belfast medical circles regarding the probable character of the medical curriculum in the Oueen's University of Belfast. It is said that the course will be a five years' one, without any pre-liminary Arts year. Examinations will be held in March and July, at the end of each session, and an examination will be held at the close of each medical year. The first will embrace the usual preliminary scientific subjects. The second year will be chiefly anatomy and physiology, which will then be finished with. The third examination will be on pathology, sanitary science, medical jurisprudence, and such subjects. The fourth will be on medicine, surgery, obstetrics, and ophthalmology, and with that examination attendance on lectures will finish; and the fifth year will be devoted to clinical work, ending with a clinical examination. Degrees will be granted on the combined results of the fourth and fifth examinations, which may be taken togther as a single final examina-tion if the student so prefers. In the clinical examination the various clinical teachers would take part, probably in some sort of rotation. If this sketch of the proposed curriculum is correct, the working of these sweeping changes will be watched with deep interest, for they promise to do away with some of the present difficulties.

### GLASGOW.

ANNUAL DINNER OF THE GLASGOW EASTERN MEDICAL SOCIETY.—This annual event was held on March 17th, Dr. Mathie, the President, in the chair. The guest of the evening was Sir Hector C. Cameron. Dr. Mathie paid a fitting tribute to Sir Hector as a distinguished clinical teacher and surgeon, and one who had gained the love and affection of his students. Sir Hector, in reply, said he could desire no better reputation than to feel he had secured the esteem of the numerous students that had passed through his hands. He re-called surgical work in the Glasgow Royal Infirmary forty years ago, and the horrible mortality that fol-lowed surgical operations from septicæmia and pyæmia, and how Lister's work had robbed surgery of its great evils and danger. Before Lister, it appeared, surgery was in a state of darkness. Sir Hector remarked that, without any change in the fabric of the Royal Infirmary, by the adoption of the teaching and practice of Lister, surgical results were obtained as good as any in even recently built hos-

St. Mungo's College.-Mr. J. T. Tullis, President of St. Mungo's College, addressed the students at the closing meeting of the winter session. He referred to the loss the College was sustaining by the appointment of Dr. Galt as Pathologist to the Sussex County Hospital. He stated that St. Mungo's College would not disappear, and that the negotiations with the University for the establishing of four clinical professors in connection with the new Royal Infirmary

were going on satisfactorily.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.—A meeting of the Scottish Division of the Medico-Psychological Association was held in the Physiological Laboratory of Glasgow University on March 19th, 1909. Dr. Oswald, the Medical Superintendent of Gartnavel Asylum, was in the chair. Among those present were Dr. Thomas Clouston (of Edinburgh), Dr. Yellowlees (of Glasgow), and Dr. Ireland, all "grand old men" in mental diseases. Dr. Mackenzie, of the Pathological Department of the University. delivered a very interesting lecture on "General Paralysis and Syphilis." He traced a close analogy between syphilis syphins." He traced a close analogy between syphins and trypano-somiasis as far as their general life history was concerned, and the effects on the brain both diseases produced. Dr. Mackenzie demonstrated the hæmolytic test as applied to germ disease, and its use in general paralysis as a diagnostic test. He stated that when iodide of potassium was administered to a patient, it could not be found in the cerebro-spinal fluid, and suggested that possibly the injections of suitable drugs or serum into the spinal canal might alleviate or possibly cure cases of general paralysis. He also emphasised the fact that microbes get used to small doses of drugs, and may not be killed by substantial doses given later on, and thus on the need of the dose of a particular remedy being given early in effective quantities. Dr. Henry Watt gave a short account of recent progress in the analysis of reactions, and demonstrated the apparatus used in this branch of knowledge, which promises to be of inestimable value in detecting early signs of brain disease.

### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

NATIONAL SERVICE AND THE MEDICAL PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—During the past twelve months several meetings of branches of the National Service League have been recorded in the daily papers, and it is to be noticed that medical men have been prominent in organising and addressing such meetings. Of course, medical men do not lay themselves open to criticism for taking part, as any citizen may do, in any legitimate political movement. It is different, however, when they pose as representing the views of the profession, as would seem to be inferred from the appearance of gentlemen occupying official positions in the profession at certain meetings lately. With such happenings, the public is likely to accept the view that the profession is all of one mind as regards compulsory service, a view far removed from the truth.

With the political aspect of the movement we have no concern, but it is more than open to question whether universal military service is of benefit to the physique of a nation. It is possible that regular drill and military discipline may improve the physical con-dition to some extent, but far outweighing any such benefits is the increase of venereal disease which we must expect if the youth of our country are condemned to barrack life for two or three years of their lives. In Germany it is well recognised that military service increases the amount of the venereal diseases, which indeed, as far as their history goes, have always been peculiarly the diseases of armies. The garrison towns of Germany are known to be the hotbeds of the most virulent forms of venereal disease, and the revelations of the life in such places made in a popular novel a year or two ago are still fresh in the public mind. This side of the question is not likely to be discussed at the tea-parties where the National Service propaganda is principally carried on, but it would be well for medical men at least to give it due consideration before preachers on behalf of the movement. appearing as f the movement.
I am, Sir, yours, etc.,
CRITICUS.

MIDWIVES V. MEDICAL MEN To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I am very pleased to note that you "do not hold yourself responsible for the opinions expressed by

your correspondents." It was with astonishment that I read in your last week's issue that Dr. Griffith maintains that a well-trained midwife should be able to administer chloroform. This is aiding and abetting the formation of an inferior order of medical practitioner with a vengeance! I hope fervently that it

will not come to pass in my lifetime.

I read in this week's *Medical Journal* of a rural nurse being driven from village to village in a smart dogcart and attending a medical man's patients with-out his knowledge and directions, etc. Now, we are in a great measure to blame for this state of affairs. We think that if we oppose the wishes of ladies serving on committees that they will by their glib tongues do us damage. Let them! Magna est veritas, et prævalebit. Let us consider the welfare of our profession and not look at medical questions from a selfish and individualistic point of view. Let us, furthermore, hold the whiphand of these lay committees, and if we see anything done which lowers the dignity of our profession and falsely exalts the position of the unqualified person, let us not hesitate to speak out, and ever keep before the eyes of the public that there is all the difference between a nurse and a duly qualified man.

I am, Sir, yours truly, S. J. Ross.

Monkhams, Bedford. March 21st, 1909.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR.—You say in your article on "Medical SIR,—You say in your article on "Medical Charity," "that salvation must come from within." From that standpoint would it help our badly remunerated profession were they to agitate for all the improvements in the education of midwives which Dr. Griffith advocates in his letter to you last week? Would it not tend to the further commercial ruin of Would it not tend to the further commercial ruin of the medical profession if what at present is an inferior order of competing medical practitioners were by the aid of doctors educated and elevated to an equality with them, and "become capable of administering chloroform, dosing with hypodermic medicaments and using specula," etc.? At present young practitioners find midwives sufficiently competitive, but if educated so that "they will not always have to be sending for the doctor," they will be much more formidable opponents. Is the speculum to be used to note the dilatation of the os, or is she to repair laceration of opponents. Is the spectrum to be used to note the dilatation of the os, or is she to repair laceration of it after completion of labour? The more ignorant the midwife remains the better for doctors. Why should we try to curtail a source of income by handing another branch of medicine over to a separate body of practitioners? Enough has been done in that direction already.

I am, Sir, yours truly, JAMES HAMILTON.

Chelsea, March 20th, 1909.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—Dr. G. de G. Griffith is quite right in his atement, The land is flooded with Midwives." statement, May I inquire what sort of berths can be found for all? Why not spell berths with an I? The profession is already poached upon from all sides, and now in order to prevent the doctor being called in, the midwife is to take a step higher than she has had and "administer hypodermics," "give chloroform," vaccinate and probably circumcise. "A little learning is a dangerous thing," and the midwife should have her exact work taught her, and be punishable should she exceed her rules, unless in cases of dire necessity. Soon nothing will be left to the medical man to practice except patience.

i am, Sir, yours truly,

ALEXANDER DUKE.

Lendon, W.

### SMALL-POX AT BRISTOL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—I am sorry to say your account of small-pox in Bristol is in many respects inaccurate and simisleading.

In the first place the disease has not become uncomfortably disseminated in the city; there have been two well circumscribed groups of cases, as detailed in the printed letter

In the second place I have not lost control of the disease in the city, and I do not fear an outbreak of some severity. The disease appears to be absolutely

under control in the city.

In the third place the Local Government Board did not send down their Medical Inspector (Dr. Sweeting) because of the prevalence of disease in the city, but because a co-existent infection of certain adjacent districts in the county rendered it necessary to secure co-operation between the neighbouring authorities and Bristol in the matter of vaccination, contact supervision, etc.

It is not internal spread that we fear, but possible

cross-infection from one district to another.

With these slight alterations, your description may

I am, Sir, yours truly, D. S. DAVIES, M.D., M.O.H.

March 18th, 1909.

[COPY.]

CITY OF BRISTOL. PORT OF BRISTOL. DEAR SIR,—The position as to Small-pox in Bristol is this:

An introduction took place in December, which led to 15 cases of small-pox, the last case being notified on March 1st.

From the country district outside Bristol another introduction took place into a Public Institution on February 16th, this case infected 7 persons in the city-all removed to hospital and doing well.

During the present week only one notification of small-pox has been received. So far as the City and Port of Bristol are concerned there is at present no epidemic in the City or Port, but the special precautions as to vaccination and re-vaccination advised by the Local Government Board, and being actively adopted, are in order to anticipate any extension in the country districts and re-introductions into the city, and to prevent extension from the cases already introduced into Bristol.

It is fully believed that these precautions, which are being taken in advance of any actual epidemic, will prevent the establishment of small-pox in the city, and the fact that reasonable precautions against invasion of disease are being taken in time instead or waiting for a wide extension of the disease is a reason for confidence in the Health Authority of the

city.

Yours faithfully, D. S. DAVIES, M.D., Medical Officer of Health.

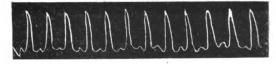
OXYGEN IN SPORT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—If not putting to too great a trial the patience of your readers, I will ask you to allow me to make a last reply to Dr. Leonard Hill, who continues to entirely misunderstand the gist as well as the text of my first letter.

Dr. Leonard Hill says: - "The inhalation of oxygen after forced exercise has no effect on the breathing volume or the breathing frequency. . The sphygmograph is not an instrument by which blood pressure can be measured; it is difficult to apply it twice without modifying the form of the tracings obtained. I, by this means, have hitherto been unable to obtain trustworthy evidence as to the effect of oxygen.

I have not written a word that could warrant the conclusion that I supposed that oxygen increased the adequacy of the lung when given after forced exercise. What I did state was that it did so when administered during exercise—that an effort can be made, thanks to oxygen so inhaled, which helps the blood through the lungs and so enables a sprint to be continued when an athlete would otherwise have been pumped out by lung failure. If this is not increasing the adequacy of the lung, I don't know what is.

Dr. Leonard Hill says, moreover, that he has not been able to show this ("obtain trustworthy evidence") by the sphygmograph; but that I have done so is shown by the tracings I published, which are to be found



in the accompanying pamphlet, and the blocks of which I send, in case you may think fit to use them.

This is the whole point: I have never claimed to have discovered the obvious. I remarked in my first letter that there was nothing new under the sun, and that oxygen had no doubt been administered by others in sport before me.

I have only claimed to have shown by "trustworthy evidence" the mechanism of the physiological experievidence" the mechanism of the physiological experiment Dr. Leonard Hill has failed to realise.

A comparison of the two tracings, the first taken from a sprinter during forced exercise and entirely pumped out—i.e., with a systemic accumulation of CO<sub>2</sub> beyond the adequacy of the lung—the second during the inhalation of oxygen, shows the restoration of tension I allude to, which can only have been



obtained by enabling the subject to go on breathing and so to deal more efficaciously with the excess of carbonic acid. This, I think, may be called increasing the adequacy of the lung.

With regard to the accuracy of sphygmographic tracings, this depends, no doubt, upon the experimenter. For my own part, I have taken thousands of them during the last thirty years, and in the same conditions I can always obtain sensibly the same tracings.

I am, Sir, yours truly, OSCAR JENNINGS, M.D.

Paris, March 22nd, 1909.

THE MEDICAL DEFENCE UNION AND INSURANCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—In consequence of the demand which has lately sprung up for insurance of medical practitioners against the risk of pecuniary loss when adverse verdicts, involving payment of plaintiff's costs and "damages," are returned against them in civil actions in their professional work, the Council of the Medical Defence Union has concluded arrangements with a company of the very highest repute, "the Yorkshire Insurance Company," for such indemnity. All members of the Medical Defence Union can now, by payment of a yearly premium of the smal lsum of 7s. 6d., effect insurance up to the limit of £2,000—and for a payment of 9s, up to the limit of £2,000—in any case defended by the Union in this respect. For fuller particulars and general conditions members are reterred to the Secretary of the Yorkshire Insurance Company (founded 1824), Bank Buildings, Princes Street, London, E.C., to whom all applications by members of the Union for policies should be made.

I am, Sir, yours truly,

A. G. BATEMAN, General Secretary.

Medical Defence Union.

INCORPORATED DENTAL HOSPITAL OF

IRELAND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-I am desired by the staff of the Incorporated Dental Hospital of Ireland to send you the subjoined resolutions adopted unanimously at a meeting of that body held in Dublin on the 8th inst.

I may inform you that the hospital staff comprises 25 dentists (8 of whom hold additional medical qualification), and 11 medical men, anæsthetists.

I am, Sir, yours truly, GEO. M. P. MURRAY, Hon. Sec.

March 15th, 1909. [The resolutions will be found on p. 308 of our present issue.—ED. M. P. AND C.]

### OBITUARY.

CAPTAIN FREDERICK HALLAM HARDY, R.A.M.C., M.R.C.S., L.R.C.P. CAPTAIN FREDERICK HALLAM HARDY, R.A.M.C.,

who died at Aden on March 8th of sleeping sickness, on the voyage home from Nyasaland, was the son of Major-General F. Hardy, C.B., of Shawford, Winchester. Captain Hardy went out to British Central Africa as a civil surgeon under the Foreign Office in 1898. He served in the Southern Angoniland expedition 1898, and received the medal with clasp. In British Central Africa, in 1899, he took part in the expedition against Nkamba, and received the medal with clasp. He was gazetted to the Royal Army Medical Corps in June, 1900. He received his commission in the King's African Rifles in 1901. In that year he took part in the expedition up the Gambia, and was mentioned in despatches and received the clasp. He was in East Africa in 1902-4 during the operations in Somaliland, and saw action at Jidballi, for which he received two clasps. In the autumn of 1906 Captain Hardy was seconded for service in British Central Africa under the Colonial Office, and was carrying out scientific research into the causes of

tropical diseases.

While treating the only case of sleeping sickness known in the country he contracted the disease, and the news of his serious illness was telegraphed home to his relatives early in January. He was placed in charge of Dr. Kinghorne, of the Liverpool School of Tropical Diseases, who was accompanying him to England.

### SPECIAL ARTICLES.

### INCORPORATED DENTAL HOSPITAL OF IRELAND. AT a meeting held on March 12th, 1909; the fol-

lowing resolutions were adopted:

I.—That the members of the staff of the Ircorporated Dental Hospital of Ireland, having had under consideration the General Anæsthetics Bill, 1908, as submitted by the Privy Council to the General Medical Council, do approve the general principles of the Bill, but are of opinion that the clauses relating to registered dentists should be modified.

tered dentists should be modified.

They would respectfully point out that dental students, before they present themselves for their final examination, are required to produce evidence of having received instruction in general medicine, surgery and physiology, as well as in the administration of anæsthetics; they are, consequently, of opinion that if the course of instruction in the latter subject were made identical for medical and dental students, the same privileges could with perfect propriety be extended to dentists as are given to medical men by Clause 1 of the Bill.

In order to give effect to these proposals they would suggest the following amendments to the Bill. That Clause I should read as follows:

That clause I should read as 1010ws:—
That any person other than a legally qualified medical practitioner registered under the Medical Acts, or legally qualified dental practitioner registered under the Dentists Act, 1878, who shall wilfully administer, or cause to be administered, to any other than the inhelation or otherwise any drug or subperson by inhalation or otherwise, any drug or substance whether solid, liquid, vaporous, or gaseous, and whether pure or mixed with any other drug or substance, with the object of producing a state of unconsciousness during any medical, or surgical, or

dental operation act or procedure, or during child-birth, shall be liable on conviction before a court of summary jurisdiction for such offence to a penalty not exceeding ten pounds, and in the case of a second or subsequent conviction to a penalty not exceeding twenty pounds, provided always that a person shall not be liable to a penalty under this section if in conducting such administration he was acting under the immediate direction and supervision of a legally qualified medical or dental practitioner, or if the cir-cumstances attending the administration were such that he had reasonable grounds for believing, and did believe, that the delay which would have arisen in obtaining a legally qualified medical or dental practitioner would have endangered life.
(2) That Clause 2 be amended as follows:—

All licensing bodies in the United Kingdom recognised by the General Council of Medical Education and Registration of the United Kingdom shall require that all candidates, both medical and dental, before presenting themselves for their final examinations, shall have received thorough theoretical and practical instruction in anæsthetics, and shall have personally administered anæsthetics, under the supervision and to the complete satisfaction of their respective teachers.

(3) That Clause 3 be deleted. Second resolution :-

II.—That no legislation which does not deal with local anæsthetics will adequately meet the mischief against which the General Anæsthetics Bill is aimed.

### REVIEWS OF BOOKS.

A SYSTEM OF MEDICINE. (a)

WE have received for review the two volumes which. in the present edition of Professor Allbutt's wellwork, take the place of the fourth volume in the original edition. Part I. of Volume IV. deals with diseases of the liver, pancreas, ductless glands, and kidney. It has undergone very considerable changes, whilst the original sections on diseases of the nose, pharynx, and larynx have been removed. An entirely new series of articles, including one on diseases of the

ear, form Part II. of Volume IV.

Part I. consists of four sections. The first of these deals with the diseases of the liver, and occupies some 200 pages. The principal contributors are Drs. A. Keith, William Hunter, John Thomson, Herringham, and Hale White. The section ends with two lucidly written articles by Mr. Mayo Robson on diseases of the gall-bladder and bile-ducts, and on gall-stones. The second section deals with diseases of the pancreas, and has been contributed by Drs. Bosanquet and Pitt. The third section deals with diseases of the ductless glands and some other conditions, such as infantilism, obesity, adiposis dolorosa, and ædema. The principal contributors are Drs. Hector Mackenzie, H. D. Rolleston, George Murray, John Thomson, and Sir Dyce Duckworth. The fourth section deals with diseases of the kidney and has been written by Professional eases of the kidney, and has been written by Professor Rose Bradford, Professor Macalister, and Mr. Henry

The volume is a most valuable and interesting one. Every article bears the stamp of authority, and is obviously written by one who is an authority on his subject. It is, we think, a pity, however, that either the Editor, or the contributors, did not make an effort to have the work as a whole properly illustrated. In the present volume there are 760 pages and nine illus-trations. Of these, four are simple diagrams, and the remainder are reproduced photographs. It is, of course, a fact that several of the subjects discussed do not require illustration, but in other subjects the reverse is the case, and the value of the articles dealing with them would have been materially increased by the addition of suitable illustrations.

The second part of Volume IV. deals with subjects

<sup>(</sup>a) "A System of Medicine by many Writers." Edited by Sir Clifford Allbutt, K.C.B., M.D., LL.D., F.R.C.P., Regius Professor of Physic in the University of Cambridge, and Humphry Davy Rolleston., M.D., F.R.C.P., Senior Physician to St. George's Hospital, &c., &c. Vol. IV. Part I, pp. xii and 784, and Part II, pp. xxvi and 586 London: Macmillan and Co. 1908.

which are not as a rule discussed in treatises on medicine. The editors recognise this, and explain in the preface the reason for the inclusion in the series of "so special and even surgical" a subject as diseases of the ear. The editors do not apply this explanation to the remainder of the volume, but as it deals with diseases of the nose, pharynx, and larynx, and as these regions have become almost entirely the domain of a surgical specialist, the explanation might equally well apply to it. However, that does not affect the merit of the volume, which, as a modern monograph on diseases of the nose, throat, and ear, seems to be

wholly admirable. This part is divided into four sections. The first deals with diseases of the nose, and has been written by, amongst others, Dr. Greville MacDonald, Mr. Herbert Tilley, Sir Felix Semon, and Dr. F. de H. Hall. The second section deals with diseases of the pharynx, and has been written by Sir Felix Semon and Dr. P. W. Williams. The third section deals with diseases of the larynx, and has been written by the same authors. It is followed by four separate articles on direct laryngoscopy, foreign bodies in the air passages, diseases of the trachea, and the throat and naso-pharynx in acute specific fevers. The fourth section deals with diseases of the ear, and is written by, amongst others, Drs. Barr, Porter, Tod, Grant, Milligan, Ballance, McBride, and Love. There are some fourteen plates, almost all of which are good and well reproduced. There are, in addition, some sixty illustrations in the text. We should be glad to say that these also are good, but with a very few excepthat these also are good, but with a very lew excep-tions they are extremely poor. We notice some that seem to have been specially drawn for the work by Mr. Sewell, and so far as the artist's part is concerned they are good. They have, however, been spoiled by careless reproduction. When will English publishers learn that half-tone blocks for use in works such as this cannot be prepared in a similar manner to that adopted in the case of an evening paper? A good drawing is worthy of a good block, and will well repay the trifling extra expense involved. Apart from the illustrations, we have nothing but praise for the fourth volume of this very valuable system of medicine.

#### THE MUSCLES OF THE EYE. (a)

This monumental monograph on the ocular muscles is, with this second volume, completed. It is a work of which the author may well be proud, even on the grounds of the evidence of industry alone. Moreover, it is a revelation, surprising in its extent, of the mag nitude of the literature which already exists upon this special subject. We drew attention to the large number of pages devoted to the Bibliography in the first volume; but in the volume before us these pages reach almost three-score-and-ten in number, which shows very plainly, not only the labour which the compilation of the work must have involved, but also that the plea advanced by the author, in justification of his task, namely, "to collect actual facts relating to the ocular muscles, arrange them in order, and state them in terms as clear and simple as possible," was scund in its inception. Ophthalmic surgeons, generally, can only feel indebted to the author for this great undertaking-an undertaking so practically conceived and successfully carried out. As showing the scope of this volume, it may be pointed out that the subject is dealt with in five parts. (1) Ocular muscle imbalance; (2) Deviations due to lesions in the extra-ocular lance; (2) Deviations due to lesions in the extra-ocular muscles or in the globe (Strabismus); (3) Deviations due to lesions in the brain or in the nerves (the paralyses); (4) Atypical movements—inflammations and injuries of the muscles; (5) Operations on the muscles. Each of these various parts is discussed exhaustively. It is interesting, among other things, to note that the author does not identify himself with that class of ophthalmic surgeons in America which is disposed to attribute so many of the ills to which flesh is heir to imperfection of the eyes. Referring to "exaggerated opinions of eye-strain," he says, "One American writer has a series of so-called 'biographic clinics,' in which he has shown that most of the persons selected for consideration had rather misanthropic views, indigestion, or ill-tempers, and, therefore, concluded that these conditions were due to imperfections of ocular muscles. . . From similar data we would be forced to conclude that Ezekiel, with his lamentations, or Job, and other less interesting gentlemen who were inclined to introspection, also were afflicted with eyestrain and suffered simply for lack of a competent refractionist. Such literary diversions are clever and popular, of course, but let us not call them even semi-scientific, or attempt to treat them seriously."

The chapter upon the operative treatment of muscle deviations deals with many interesting and important points. "Some operations," he says, "on the ocular muscles demand as much care and exactness for their proper execution as operations upon the iris and lens." Again: "Among the multitude of operations which have been proposed for advancement, it is difficult to single out any one which is pre-eminently the best." He defines the choice between an advancement operation and tenotomy as follows:—"Advancement is always indicated for a typical passive deviation, usually for a composite deviation, and it is possible to produce improvement with it in an actual deviation. Tenotomy, however, is much the simpler operation. It is especially indicated for all actual deviations, and the good results constantly obtained with it in this class of cases, and sometimes in cases of the composite type, cause tenotomy to hold its place in spite of theoretical objections." Possibly to this chapter ophthalmic surgeons will turn for reference more than to any other.

### A PHILOSOPHY OF NATURE. (a)

NOTHING has been more striking in the history of the philosophy of science as it concerns our generation than the return that has been made by scientific minds to concepts long regarded as illegitimate. A few years ago the physiologist thought he was only at liberty to make use of chemical and physical laws in the explanation of the phenomena in his department of science, and the biologist in his wider sphere guided himself by the same canons of thought. The concept himself by the same canons of thought. The concept of life, of the "life-force" of the older physiologists, was banished as something superstitious and quite alien to the scientific categories. But those days are past, and at the last meeting of the British Association the President of the Physiological Section forecast the bankruptcy of the old ideas and the necessity of again taking life and the phenomena of life into consideration. In this fresh conspectus, chemistry and physics are to be regarded as insufficient, and every concept in our armoury of ideas is to be given its chance.

It is in some such spirit as this that Mr. T. W. Rolleston has been thinking, and he has given us the result of this thought in a neat volume. Mr. Rolleston has long been known as a polished and scholarly writer on literary subjects, but we think that this is his first original essay in the direction of science or philosophy. He has shown that he has followed very closely the writings of modern biologists, and he has got a good grasp of their views. In philosophy he is, as we hope to show, an original thinker, while as regards his literary expression we are pleased to find that his change of subject-matter has not made Mr. Rolleston's hand forget its cunning.

In the earlier part of his essay Mr. Rolleston argues,

and, we think, argues convincingly, against the purely mechanical theory of the universe. The living being is essentially different from a machine. The term "living machine" is a contradiction, since what is peculiar about a living thing—its power of construct-

<sup>(</sup>a) "The Muscles of the Eye." By Lucien Horne, M.A., M.D. In two volumes. Vol. II, Pathology and Treatment. Illustrated, New York and London: G. P. Putnams Sons. 1908.

<sup>(</sup>a) "Parallel Paths: A Study in Biology, Ethics, and Art." By T. W. Rolleston. 8vo. Pp. xvi. and 300. London: Duckworth and Co.

ing itself, of adapting itself to its surroundings, is precisely what a machine cannot do.

Again, Mr. Rolleston attempts to assign to the Darwinian hypothesis its place in the scheme of the universe. He is by no means an anti-Darwinian, and he gives to the doctrine of natural selection all that can be claimed for it in the explanation of development. But the doctrine of natural selection only explains the how of evolution; it leaves the why still to seek. It is as if someone were to explain a railway system by pointing to the metals, and the sleepers, and the permanent way, but were to say nothing of the force of steam which makes the engine to travel. Natural selection is the path along which the X-force has made us to travel. What is this X?

This is the problem Mr. Rolleston sets before him, and he pursues it through the domains of biology, ethics, and art. We do not think he defines it anywhere in set terms, but he tells us (p. 155) that it "is a controlling and directing force, making, through countless varieties of being, for one clear and definable end—the realisation of life." We know no force but by its effects, and therefore this description is not as empty as one might think. "The realisation of life" is the end, the controlling force, which has guided us along the paths of evolution. Mr. Rolleston follows this out in ethics and art. "We have before us," he says (p. 234) "a clear conception of the criterion and the sanction of ethical action. The criterion is applied when we ask of anything done by man, 'Does it further life in the whole?' The sanction is found

whole." His judgment of art is by the same criterion. What Mr. Rolleston has made clear is the necessity for some other principle than purely mechanical ones in the explanation of the universe. The principle he chooses—Life—it may be objected, is somewhat void and vague. This is true, but it is necessarily so, and we can only hope to make it less void and vague by a careful study of the phenomena by which it manifests itself

in the fact that each of us is an organic part of that

The book should be read by everyone with a philosophical turn of mind who wishes to learn something of the fundamental principles which underlie modern science.

### CLINICAL DIAGNOSIS. (a)

In the preface to the first edition of this work is a paragraph which is worth quoting at length. Dr. Emerson writes: "The function of the clinical laboratory worker is to aid the ward worker. The findings of the former are seldom conclusive, and must be interpreted in the light of the ward findings. . The clinical chemist must be first a good clinician and second a chemist; he should remember that even from the laboratory point of view his stethoscope is of more importance than his microscope, his percussion finger than his whole outfit of chemical apparatus." It is not surprising that, with this conception of what a laboratory worker should be, the author has written a book on clinical diagnosis of which a second edition is required after only two years. Much of the book has been rewritten, and it has been considerably amplified, so that the subject is very fully dealt with. There are many excellent illustrations, which greatly enhance the value of the text, indeed, several coloured plates are the best we have seen of the subjects which they depict. work is divided into six chapters, the first deals with the examination of the sputum, and though comparatively short, gives an exhaustive description of the various kinds of sputa and the numerous objects to be found in them. This chapter is followed by the longest in the book on the examination of urine. In it the value of cystoscopy as a means of determining the kidney efficiency is keenly criticised, but no mention is made of Sir Almroth Wright's method by hæmolysis, which is not open to the same objections. It is not surprising, then, that under functional albuminuria, although the condition is described especially carefully, it is not stated that the kidney efficiency is normal, a truth which was arrived at by the hæmolytic method. Chapter 3 deals with the examination of the gastric contents. We think that undue importance has been given to the presence or absence of free hydrochloric acid, as opposed to the amount of active hydrochloric acid; and would welome the addition of Willcox's method of estimating the latter. If this were employed it would perhaps lead to a modification of the author's rather pessimistic attitude towards the likelihood of early diagnosis in cases of gastric carcinoma. Chapter 4 concerns diagnosis by examination of the fæces. Hæmatology follows in Chapter 5, which is replete with especially beautiful illustra-tions of blood films and of the malarial parasites. To English readers it appears strange that Leishman's stain is not mentioned specifically. A careful account of the opsonic method is given, but we think that the pipette illustrated, for the collection of blood from the finger, is unduly cumbersome, and possesses no advantages over that introduced by the originator of the method. Chapter 6 contains an account of the characters of the various other body fluids, normal and abnormal. It is short relatively to the rest of the book.

### DISEASES OF THE EYE. (a)

THE author's object in writing this book was to present to students and to practitioners a short, practical manual of diseases of the eye; and for this reason he avoids any theorising or discussion, but keeps himself to hard facts, and devotes more attention to the practical side of his work by dealing more fully with the diseases most frequently met with in general practice than with those of the deeper tunics of the eye.

The first 64 pages are given to methods of examination and elementary optics and refraction, and, as might be expected, the subjects have to be treated in a rather sketchy way when such a limited space is set apart for them. We must say, however, that the author has made the best of it. There is a bad "slip" on page 35, where it is stated that retinal images, to be appreciated as separate objects, must subtend an angle of 5°. The error is repeated on page 56. As the work is one meant for beginners, the reviewer may be permitted, in the interests of the subject, to further take exception to the letters on page 57 being called "Sneller's test types." Having got past these pages, the book comes out in its true light. The various diseases of the conjunctiva, cornea, sclerotic, etc., are dealt with in a very concise, practical way, the treatment being to the point, and alternatives omitted in The chapters on the conjunctiva, retina, and ocular muscles struck us as particularly good. On page 210 we are told that "opaque nerve fibres" are flail-like in shape. We fancy "flame" or "tail"-like would be happier similes, besides being more readily recognised. The illustrations are mostly original and very good, many being micro-photographs of pathological conditions such as diseases of the retina and optic nerve, and of glaucoma. We wish Mr. Mayou's book the success which it deserves, for it must appeal to a large number of students who are seeking an elementary multum in parvo at a modest price.

### MEDICAL NEWS IN BRIEF.

Semon Testimonial.

A GENERAL meeting of laryngologists was held at the Royal Society of Medicine on March 5th to organise a testimonial to Sir Felix Semon on the occasion of his retirement. This takes place at the end of the coming June.

Mr. Butlin was unanimously elected Chairman of

Mr. Butlin was unanimously elected Chairman of the General Committee, and Dr. Dundas Grant, President of the Laryngological Section, was elected Chairman of the Executive Committee, which consists

 <sup>(</sup>a) "Clinical Diagnosis." By Charles Phillips Emerson, A.B.,
 M.D. Second Edition. London: J. B. Lippincott Co. Price 21s.
 net. 1908.

<sup>(</sup>a) "Diseases of the Eye." By M. Stephen Mayou, F.R.C.S., Assistant Surgeon and Pathologist. Central London Ophthalmic Hospital. Pp. 380, illustrated. London: Henry Frowde, and Hodder and Stoughton 1908.

of the following:—Mr. Butlin (Chairman General Committee); Dr. Dundas Grant (Chairman of the Executive Committee); Mr. Charters Symonds; Mr. Cresswell Baber; Dr. J. B. Ball; Dr. Law; Dr. McBride; Mr. Herbert Tilley; Mr. E. Waggett; Dr. Sandford; Dr. de Havilland Hall; Dr. Scanes Spicer; Dr. St. Clair Thomson (Hon. Treasurer, 28 Queen Anne Street); Dr. Watson Williams (Hon. Secretary, 4 Clifton Park Bristol): Dr. H. J. Davis (Hon. Sec. 4 Clifton Park, Bristol); Dr. H. J. Davis (Hon. Secretary, 8 Portman Street, London, W.). Subscriptions may be forwarded to the Honorary Treasurer.

### Irish Medical Schools' and Graduates' Association.

ABOUT two hundred ladies and gentlemen sat down to the festival dinner of this Association, held at the Hotel Cecil on Thursday, March 18th. In the unavoidable absence of the Right Honourable Lord Ashavoidable absence of the Right Honourable Lord Ashbourne, the chair was occupied by Dr. François A. de Thierry Mouillot, who was supported by a large number of distinguished men, amongst whom may be mentioned Sir Robert Ball, Prof. Arthur Barker, of University College Hospital, Sir Alfred Keogh, K.C.B., Surgeon-General W. L. Gubbins, C.B., M.V.O., Surgeon-Colonel John J. de L. Marshall, Dr. L. S. McManus, Mr. Canny Ryall, Dr. P. S. Abraham, Mr. Chas. Ryall, Mr. W. Ernest Lane, Dr. Dawson Williams, Mr. John Murray, Dr. Voelcker, Mr. Willmott Evans, Mr. Stonham, C.M.G., Dr. Wm. Hill, Dr. Herschel, etc., etc.; also, Lieut. G. Abraham, R.L.M.I., and Lieut. John Smith McCombe, R.A.M.C. After the usual loyal toasts had been duly honoured, Dr. Jameson Macan, Chairman of the Council, intro-R.L.M.I., and Lieut. John Smith McCombe, R.A.M.C. After the usual loyal toasts had been duly honoured, Dr. Jameson Macan, Chairman of the Council, introduced Lieut. John Smith McCombe, R.A.M.C., to whom the Chairman presented the Arnott Memorial Medal as a recognition of Mr. McCombe's bravery in attempting to save the life of a youth who fell into the river off Millbank. Although Mr. McCombe's efforts to save the boy were unsuccessful, owing to the muddy condition of the water preventing his repeated dives from carrying out his intention, he continued his search until he himself was so exhausted that he had to be assisted ashore. The toast of "Our Defenders" was ably proposed by Dr. James Macdonald and responded to by Lieut. G. J. Abraham, R.M.L.I., Sir Alfred Keogh, and Colonel J. de L. Marshall, the latter showing that officers of the Territorials could at least hold more than their own in after-dinner oratory. Dr. L. S. McManus then, in a witty speech gave "Our Guests," the toast being responded to by Surgeon-General Gubbins. The best discourse of the evening was then pronounced by Sir Robert Ball, F.R.S., in proposing "The Association." ite gave some very amusing reminiscences of Sir P. Crampton and of Dr. Haughton. "The President" was proposed by Dr. Edgcome, and with Dr. Mouillot's answer a very enjoyable evening was brought to a close, although we do not think the musical and variety entertainment was up to the usual mark of the dinners of the Association; in fact, with musical and variety entertainment was up to the usual mark of the dinners of the Association; in fact, with regard to the variety portions (thought reading, etc.), it seemed to us that the only people who could appreciate the performance were those in the immediate vicinity of the performer.

#### ion Ophthalmic Hospital Guild.

THE annual meeting of this guild, which is composed of ladies engaged in working for the support of the Royal London Ophthalmic Hospital, was held on March 16th at the hospital, Mrs. Adler presiding. The report, which was read by Mrs. Marcus Gunn, stated that the amount collected in 1908 showed an increase of £53 over that in 1907. The collection towards the cot fund was also satisfactory. The sum of £100 had again been contributed by the guild for the upkeep of a cot and bed, and £157 had been expended by the works committee. There were now 270 members of the guild, Mrs. Adler, in moving the adoption of the report, emphasised the urgent need of additional financial support. Only a few days ago she saw lying in the children's ward a baby who was born blind, but, owing to the skill of the physicians and surgeons, there was every probability of its receiving sight, while hundreds of others with imperfect vision were saved from becoming totally blind. Patients came to

the hospital from all parts of the country. Miss A. S. Lawrence, in seconding the motion, said that 6,000 children attending the London elementary schools had defective eyesight and required to attend the eye hospitals as out-patients, yet the total accommodation of all the I ondon eye hospitals was equal to dealing with only 10,000 a year. The report was adopted.

#### Disinfection of Anthrax.

Dr. J. S. Holden, medical officer of health for Melford, has frequently reported on the occurrence of anthrax among employees in a local workshop where foreign and raw horsebair is largely handled. Just before the new Anthrax Order was issued by Home Office last year, three cases of anthrax suddenly occurred in this workshop. He suggested that each bale of horsehair, just as received, should first be thoroughly soaked in a hot antiseptic dilution, and then opened and sorted while still damp, so that no dust could possibly fly about. The owners of the workshop and the Inspector of Factories approved this suggestion and advised that it might be substituted for the new Anthrax Order. Application was made to the Home Office and the certificate granted. The process adopted is, that each bale of horsehair is immersed in a tank containing I per cent. or more of Cyllin in hot solution. In this position the bale is ripped open, so that the hair gets well soaked; after 1½ hours' immersion the hair is drained and then sorted. Dr. Holden reports that since this process was commenced early in April, no case of anthrax has occurred, and all dust is effectually prevented.

#### Spotted Fever near Klimallock .

THE family of a labourer, residing at Bantard, Co. Cork, has been attacked by cerebro-spinal fever, from the effects of which two members of it have died, and a third is seriously ill. A few days since a child, æt. 4 years, got unwell, and died on Wednesday or Thursday; a boy, æt. 6 years, also got indisposed, and died yesterday (Friday), while the sister, æt. 7, has been removed to Kilmallock Union Hospital, where she lies in a precarious condition. The disease is pronounced to be cerebrc-spinal fever.

#### Vital Statistics.

THE deaths registered last week in the eighty great towns of the United Kingdom corresponded to an annual rate of 22.1 per 1,000 of their aggregate population. In the preceding three weeks the rates had been 18.1, 19.1, and 21.3.

Measured by last week's mortality, the highest

Measured by last week's mortality, the highest annual death-rates per 1,000 living were:—From all causes, 27.0 in Stockport, 26.2 in Liverpol, in Bootle and Salford, 35.1 in St. Helens, and 27.5 in Dublin, 27.0 in Birmingham, 29.0 in Bury, and 34.6 in Brighton. The death-rate from measles was 4.7 in Sheffield, 4.0 in Birmingham, 5.9 in West Hartlepool, 7.2 in Warrington, 4.9 in Aston Manor, and 12.6 in St. Helens. No death from small-pox was registered in any part of the United Kingdom. any part of the United Kingdom.

### Society of Apothecaries of London.

The following candidates, having passed the necessary examinations, have received the L.S.A. Diploma of the Society, entitling them to practice Medicine, Surgery, and Midwifery:—W. C. D'Eath, J. M. Fishe, W. N. Pickles, N. S. Shenstone, and S. H.

A RUSSIAN emigrant from the Hague, who intended to sail for New York on March 13th, was attacked by small-pox, and isolated immediately. Prcbably other inmates of the Holland-America Line's emigrants' shelter will undergo quarantine before being allowed to embark.

THERE have been two cases of small-pox in London since a patient was admitted to the Joyce Green Hospital from Camberwell last month. These have occurred in Westminster and Hackney. The latest return shows that two cases now remain in hospital.

### NOTICES TO CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Eubscriber," Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), &s. 6d. per insertion; 6d. per line beyond.

6d. per line beyond.

Stornowat.—Some of the witnesses before the Departmental Committee upon the Inebriates Acts did not heaitate to assert that it is a penal offence to get drunk, so as to lose control of one's actions. It is a moot point, however, in point of law whether any legal offence is thereby committed, although drunkenness does not excuse a man for wrong-doing when in that state. An important point bearing upon the liberty of the subject is involved, and our correspondent would do well for refer to some legal authority on the subject, say, the Law Journal. The tendency of recent legislation has been in the direction of rendering drunkenness an offence

MR. CLEMENT SERS .- Your letter is unavoidably crowded out of our present issue.

PHARMACIST (Jersey).—Your letter to hand last week regarding the poisonous dose of quinine. In fevers and malaria patients are able to withstand amounts far in excess of the average dose. Curiously, a case was investigated by Dr. Danford Thomas on the 21st inst. at the Marylebone Coroner's Court. The deceased was 56 years of age, a strong and healthy woman, who had taken 25 grains. Death resulted from cardiac paralysis paralysis.

THE WOES OF A HOSPITAL PATIENT.

Hospital patient (bricklayer) recounting his experience to patient in next bed.

Oh, yes, I've been to all the hospitals, St. George's, Bart.'s, and Guy's,
And when I'm out again at work my mates stare with

surprise.

I've had bronchitis, pleurisy, no wonder I am vexed With chilblains and the whooping-cough, I wonder what comes next?

comes next? The jaundice and the dysentery has left me just a wreck, Dyspepsia and the stomach-ache have knocked me off my

peck.
But well I know they'll patch me up, and do their best for me,
Till I get the bloomin' leprosy, and then I'm "up a tree."
A. D.

AN OBSCURE PRACTITIONER.—Your communication unavoidably

A. F. Marsh (Worthing).—The Poor-law Commission take the pessimistic view that "once a casual always a casual, unless there is within the individual some special grit and force of character to emancipate him from his vicious and retentive environment." It seems evident that society is out of patience with the casual tramp, and that some drastic plan for dealing with this unhappy product of our social system must be found. found.

ZOSTER.—You should call on this superseding practitioner, and have the matter out with him in a friendly way. It is a pity to he "touchy." The British public can select its own medical attendants, as long as it does not confuse or mix up two medical

### Meetings of the Societies, Tectures, &c.

WEDNESDAY, MARCH 24TH.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenics Street, W.C.).—4 p.m.: Mr. C. Ryall: Clinique (Surgical), 5.15 p.m.: Lecture: Mr. L. Munumery: The Pathological Causes and Surgical Treatment of some Cases of Severe Chronic Constipation

STIPMENDAY, MARCH 25TH

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne
Street, Edgware Road, W.).—8.30 p.m.: Mr. A. J. Pepper:
Thirty Years' Hospital Experience and Practice.
ROTAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—
5 p.m.: Dr. N. Moore: Rheumatic Fever and Valvular Disease.
(Lumleian Lectures.)
MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies
Street, WC.).—4 p.m.: Sir Jonathan Hutchinson: Clinque

(Surgical). 5.15 p.m.: Lecture Dr. H. Walsham: The Diagnosis of some Obscure Diseases of the Chest by X-Rays.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Walse's General Hospital, Tottenham, N.).—2.30 p.m.: Gynrecological Operations (Dr. A. E. Giles). Clinics: Medical Out-parient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. G. P. Chappell).

ST. JORN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Sqare, W.C.).—6 p.m.: Mr. C. Williams: Electro-therapuetic Methods in Some Skin Diseases.

FRIDAT, MARCH 25TH

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. W. Wingrave: Clinical. Pathology.

### Appointments.

BERRY, WILLIAM, F.R.C.S.Irel., D.P.H., Superintendent School Medical Officer by the Education Committee of the County Borough of Wigan.

DAVIS, H., Junr., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon-under the Factory and Workshop Act for the Callington District of the county of Cornwall.

GIBBS, STANLEY RIDER, L.R.C.P.Lond., M.R.C.S., Medical Officer-for the Second District by the Barnstaple (Devon) Board of Guardians.

HARMAN, N. BISHOP, M.B.Cantab., F.R.C.S.Eng., Assistant Ophthalmic Surgeon to the West London Hospital, and Lecturer in Ophthalmology to the Post-Graduate College.

KAUFFMAN, OTTO JACKSON, M.D.Lond., Medical Referee under the Workmen's Compensation Act, 1906, for County Court Circuit No. 21.

Circuit No. 21.

MACKINNON CHARLES, M.B., C.M.Glasg., Medical Officer and Public Vaccinator by the Circuoster (Gloucestershire) Board of Guardinas,
NICHOLSON, GILBERT W., B.C.Cantab., First Assistant to the Research Department at the Court Cancer Hospital, Fulham Boad, S.W.

Road, S.W.

ROBERTS, W. EDGAR, M.R.C.S.Eng., L.R.C.P.Lond., Senior

Casualty Officer to the Royal Infirmary, Hull.

### Bacancies.

Belmullet Union.—Medical Officer. Salary £160 per annum, with £10 as M.O.H. and vaccination and registration fees. Immediate application to E. H. Flynn, Clerk of Union (See

Bartholomew's Hospital, E.C.-Assistant Pathologist.

St. Bartholomew's Hospital, E.C.—Assistant Pathologist. Salary, £300 per annum. Applications to Thomas Hayes, Clerk. Middlesex County Asylum. Napsbury, near St. Albans.—Fourtir Assistant Medical Officer. Salary £160 per annum, with furnished apartments, hoard, washing, and attendance. Applications to the Medical Superintendent. Carshalton.—The Children's Infirmary.—Assistant Medical Officer. Salary £150 per annum, with board lodging, and washing. Applications to the Clerk to the Board, Embankment, London E.C.

Applications to the Medical Superintendent.
Carshalton.—The Children's Inframary.—Assistant Medical Officer.
Salary £150 per annum, with board lodging, and washing.
Applications to the Clerk to the Board, Embankment.
London, E.C.
Warrington Infirmary and Dispensary.—Senior House Surgeon
Salary £120 per annum, with board, residence, and laundry.
Applications to J. H. J. Hampson, Secretary.
Royal Victoria Infirmary, Queen Victoria Road, Newcastle-uponTyne.—Pathologist and Lecturer on Pathology to the University of Durham College of Medicine Salary. £400 a year.
Applications to the House Governor, Royal Victoria
Infirmary, Newcastle-upon-Tyen.
Essex County Council.—Three Assistant School Medical Officers.
Salary £250 per annum, with allowance for travelling
expenses. Applications to Dr. Thresh, County Medical
Officer of Health, Chelmsford, Essex
Inverness District Asylum.—Junior Assistant Physician. Salary
£100 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent.
Barnsley.—House Surgeon. Salary £100, with board and
lodging. Applications to R. F. Pawsey, Hon. Sec., Barnsley.

### Births.

DEAN.—On March 16th, at 29, Wieland Strasse, Charlottenburg, Berlin, the wife of H. R. Dean, M.A., M.B. (Oxon).
M.R.C.P., of a son.
SANDFORD.—On March 18th, at Frankfield House, Cork, Lady Carbery, wife of Arthur Sandford, M.D., prematurely, of a daughter (still-born).

### Beaths.

EDTE.—On March 16th, at Cawnpore, India, of cholers. Surgeon-Major J. E. Edye, R.A.M.C., elder son of the late Captain Joseph Edye, C.B., R.N

FISHBOURNE.—On March 16th, at Staines Lt.-Colonel J. E. Fishbourne, R.A.M.C., M.D., F.R.C.S.I., aged 67, son of the late Robert Moore Fishbourne, of Hollymount, Carlow.

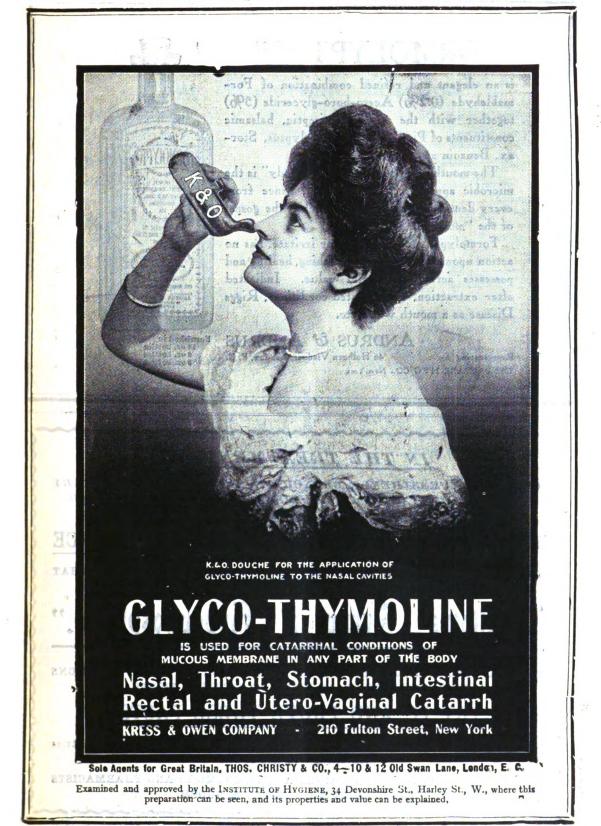
POWELL.—On March 18th, at 62, Wimpole Street, London. Juliet, wife of Sir Richard Douglas Powell, Bart., M.D.

ROBERTS.—On March 19th, at Oakleigh, Eltham, Arthur Roberts, M.R.C.S., L.R.C.P., late of 30, Kensington Square, London.

STEDMAN.—On March 16th, at 23, Orchard Road, Eastbourne, Frederic Savignao Stedman, Surgeon-Major, late Bombay Army, aged 80.

Army, aged 80.

STIRLING.—On March 19th, at 4, Laverockbank Road, Edinburgh, of pneumonia, James Hutchison Stirling, LL.D., F.R.C.S.E., in his 89th year.



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  - B Ferri Citratis Viridis 0'05 gm. [gr. 3/4] Sodii Amenatis ... 0'002 gm. [gr. 1/32] Aquem ... ad I c.c.
- " Morphine Hydrochloride, 0.01 gm. and 0.02 gm. [gr. 1 and gr. 1]
- " Quinine Bihydrochloride, 0.2 gm. and 0.4 gm. [gr. 3 and gr. 6]
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Fig. 2

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### THE MEDICAL PRESS AND

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Vol. CXXXVIII.

WEDNESDAY, MARCH 31, 1909.

No. 13.

### Notes and Comments.

**Ambulance** Service for London.

THE Committee appointed by the Home Secretary to inquire into the ambulance needs of London issued their Report last week, and we hope that now there will be no delay in

fulfilling what has long been a crying need in the metropolis. That the mighty congerie of cities which we call London, with its thousands of street accidents, should have nothing in which to remove the victims and no means of rendering effective first aid, is a reproach to its civilisation-almost as great as if it possessed no fire brigade. The Committee are unanimous on the establishment of an ambulance service, and on the traction being by motor. They recommend that eight stations should be set up in the administrative county, each with an establishment charge of  $\mathcal{L}_{1,500}$  a year. As to which authority shall undertake the work there is a division of opinion. Sir Kenelm Digby and Lord Stamford favour the Metropolitan Asylums Board, and Sir William Collins, who knows the needs and conditions of London municipal life as few others do, favours the County Council, or, failing them, the police. It is really difficult to accept the majority proposal seriously, as everybody connected with administrative matters knows that the Metropolitan Asylums Board is only marking time till it is absorbed into the County Council.

MOREOVER, if there were no other M.A.B. reason, the fact that the Metropolitan Asylums Board is already the L.C.C. ambulance authority for infectious

cases should preclude it from being endowed with this totally fresh set of duties. To begin with, there would be endless confusion as to which type of ambulance was needed in emergencies, and unless the infectious ambulance stations were entirely distinct from the accident ones, there would always be the risk of infection passing to the latter. There is a great deal to be said for the police being the authority, as it is chiefly through them that accident ambulances would be required, and any complaints could be dealt with directly, and not by circumlocutory letters passing from one authority to another, each, perhaps, a little jealous of the other's powers. On the other hand, the government of London is drifting, and very properly drifting, into the hands of the County Council, which is becoming the Parliament of London. As such it will attract men of high status and greater enthusiasm than many of those who have served on local bodies in the past, men governed by a sense of public duty, and not possessed of axes in need of grinding. There can be no doubt in every mind that every fresh duty pertaining to the whole of London should be assigned to the Council.

The Germ of Trachema.

THE news from Berlin that Professor Greef has discovered the pathogenic organism of trachoma must excite keen interest amongst ophthalmolo-

gists throughout the world. It comes with the weight of authority, inasmuch as the learned Professor is Director of the Berlin University Eye Hospital, and his observations will doubtless be rigorously tested forthwith in many lands. Among the micro-organisms that we may assume underlie many well-marked infective maladies, that of trachoma appeared to be one of the most elusive. The disease runs so definite a course, and is so lingering and so contagious, that it was difficult to account for its natural history on any theory other than that of a specific microbial origin. Some of the best work done in the treatment of school trachoma was achieved years ago in the Central London Schools at Hanwell, where Mr. Sydney Stephenson showed that it was possible to isolate trachomatous children without interruption to their education. At the same time, it was shown that trachoma could be weeded out of Poor-law institutions, and that, however lingering its nature, it was nevertheless curable in the course of time, even if the period were extended over several years. The Hanwell Isolation Schools for Ophthalmia marked a great scientific advance in the treatment of a disastrous disease.

Means.

That the discovery of a specific germ What in trachoma—assuming the feat to the Discovery have been accomplished—must one day bear fruit can hardly be doubted.

If we may judge from the length of time that has elapsed before the demonstration of the organisms of tuberculosis and malaria has led to great preventive results, we may have to wait a long time before any such discovery will lead to the extermination of trachoma. One important state-ment, however, accompanies the news from Berlin, namely, that Professor Greef has ascertained that the infectivity of trachoma is confined to its early stages. If that be true it must materially modify our future attitude with regard to isolation. Meanwhile, we have to await fuller information than that afforded by a brief telegram. In dealing with many specific infectious diseases it is a comfort to reflect that a satisfactory system of prevention and of cure has been arrived at, even in the absence of the full facts of ætiology. In this case we doubt if any more sound and practical plan of facing the problem of school trachoma could be devised than that applied by Mr. Stephenson many years ago at Hanwell.

LAST week, in the Court of Appeal, yet another human calamity was Sunstroke classed by the judges as an accident. 28 The case in question was an appeal Accident. from a decision of a County Court judge, at Southampton, who ruled that the dependants of a sailor who had died of sunstroke off the coast of Mexico were entitled to an award under the Workmen's Compensation Act, the said sunstroke being an accident within the meaning of the The fact of the matter is that the law has got itself so inextricably mixed up on this question of accident that it is impossible to see where these decisions will carry us to eventually. The other day it was held that an agricultural labourer who was struck and killed by lightning whilst engaged in ploughing had not met with an accident, on the ground that the occurrence was an act of God. Few of the most sceptical would dispute this selfevident proposition, but even the most subtle brain would be puzzled to show that a sunstroke is not an act of God, when a stroke of lightning is. It would be a rather amusing exercise to ask a court of highly-placed judges to formulate a definition of an accident based on the particular decisions of all the Courts which have pronounced on the question in the last ten years. We cannot flatter ourselves, however, that they are likely to oblige our curiosity.

Mistura
Ferri
Gallici.
THE medicinal egg, last heard of about two years ago in America, has now reached this conservative country. The discovery has been made by the Daily Sketch of Man-

chester, one of whose young lions had been interviewing the proverbial London doctor. This enterprising youth has been informed by his elusive victim that the eggs of hens fed on iron are especially useful for delicate persons requiring iron in minute quantities. "Several farmers in Surrey (why Surrey?) who have recognised the commercial value of 'iron' feeding, command high prices for their produce from hospitals, sanatoria, and nursing homes." It is perhaps significant of the backwardness of the medical profession in London that they have to learn of these ferruginous eggs from a lay Manchester journal. The method of producing this tonic nutriment, we learn, consists in scattering iron rubbish in the hen-runs and placing rusty nails in the drinking-troughs. We now begin to understand the Admiralty policy of scrapping old battle-ships: it is evidently done with the idea of promoting the national physique by supplying His Majesty's subjects with iron in the surreptitious and nutritious form of the humble and homely egg, but, seriously, we could only wish that this type of journalistic rubbish had no more substantial existence than the iron rubbish it prates of.

### LEADING ARTICLES.

TUBERCULOSIS AND DAIRY FARMS.

ALTHOUGH the essential genius of British preventive medicine lies in its practical nature, there are, nevertheless, times when the chariot-wheels appear to drag somewhat heavily. A delay of that kind is now vexing the soul of the sanitarian in the long-deferred measures for the stamping out of tuberculous cattle in dairy farms. The Royal Commission has spoken out decisively as to the infectivity of bovine tuberculosis, so far as the human species is concerned. Nor is their voice less uncertain as to the spread of tuberculosis, both to

children and adults, through the agency of infected milk. Then comes the practical man who, seeing that a vast amount of tuberculosis is preventable if attacked at its source of origin, namely, the dairy cow, demands that a rigorous control shall be exercised over the public milk supply at every stage of its collection and distribution. The only logical solution, indeed, appears to be the compulsory slaughter of tuberculous cattle. So extensive a destruction of property could hardly be exacted without a scheme for adequate compensation. It is there that the crux of the reform is reached. The nation will be asked to spend a vast sum in exterminating tuberculous cattle, and unfortunately it appears to be almost hopeless at the present moment to expect any great public expenditure upon a purely social matter. Yet the price of a single warship of the Dreadnought type would pay for the destruction of many herds of diseased cattle. Some day or other, when the international race for military and naval supremacy has had its day, the nations of the world will have time to turn their attention to the infinitely more worthy problem of the preservation of life by the elimination of infective agencies inimical to the safety of mankind. Meanwhile, the metropolis, with its enormous milk-consuming population, is at length taking steps to reduce the incidence of milk-borne tuberculosis. The Public Health Committee of the London County Council, in whose hands the matter is entrusted, have recently issued a memorandum as to their operations from October to January last in dealing, under the Council's General Powers Act, 1907, with the milk coming into London, in order to discover any which might The magnitude of their field of be tuberculous. operations may be gathered from the fact that milk is sent from at least twenty-one counties, from all of which numerous samples have been collected at the stations of delivery. The examination of 283. samples during the period under review showed that 22, or 7.7 per cent., were tuberculous. In addition, the bacteriologist reported 52 others which had proved pathogenic to guinea-pigs, but which required a further period of time for identification. The Council's inspector visited 62 farms outside the county of London, and inspected 2,029 cows, of which 74 (or 3.6 per cent.) were suffering from tuberculosis of the udder. In one case in which the examination of a sample of milk taken from a churn at a London railway station had given a positive result, the inspector found that the farmer concerned had obtained his milk from 18 other farms in the district Upon inspection of all the cows (254) at those farms, he discovered 11 (4.3 per cent.) suffering from tuberculosis of the udder. In every case in which a tuberculous udder had been diagnosed, the dairy farmer or his representative had undertaken to sell no more milk from the affected animal. That amount of protection, it need hardly be pointed out, established a great advance in this particular branch of prevention, but it would be infinitely safer were all such cows destroyed. It is reassuring to learn that the rural are falling into line with the urban sanitary authorities. The Committee have been in communication with the local authorities in whose districts infected cattle were found, and they were

informed; that two or three of those authorities had recently appointed veterinary inspectors to deal with the work. That report is encouraging, but it is of course obvious that the greatest care should be taken to select veterinary surgeons competent in this class of investigation, otherwise the object of the whole organisation is likely to be defeated. The London County Council may be congratulated upon the thoroughness with which this particular task has been discharged, and milk consumers upon the additional security they are deriving from the gradual extension of efficient control over the area of production.

## SOME OF THE EFFECTS OF THE WORK-MEN'S COMPENSATION ACT.

An interesting paper has recently been published by Sir John Gray Hill, an ex-President of the Incorporated Law Society, in which he discusses the law of employer's liability. The paper deals with much which is outside the purview of a medical journal, but it also contains many references and much information of interest to the medical practitioner. Of special interest is the author's opinion on a point which has been often raised in these columns, namely, that in view of the conflicting medical evidence so often adduced as to the amount and probable duration of the incapacity to work resulting from an accident, there should be medical assessors appointed to assist county court judges. He further considers that such assessors should be men of eminence, whose reward should be proportionate to the importance of the task which they undertake. Sir John Hill quotes the remarks made by Professor Pye-Smith on the injurious effect which the Act has on the morale and self-respect of the working-man, who, instead of trying to get quickly over his accident and return to his work, seeks to persuade himself and his medical examiners that he is incapacitated for work long after he has actually recovered. Another most important point on which Sir John Hill comments is on the injustice which arises when an injured workman refuses to submit to a surgical operation which would lessen his incapacity for work and which would entail no great risk or suffering, and he points out the necessity of so amending the law that under these circumstances the compensation allowance would cease. At the present time it is possible for an injured workman, first to decline operation, then to commute his weekly compensation allowance for a lump sum as compensation for "permanent incapacity," and then to enter a hospital and have his "permanent incapacity" removed at the expense of the charitable! It must be obvious to anyone except a sentimental humbug that, if it is one man's privilege to obtain compensation from another on the ground of an alleged injury, it must also be the other man's right to ascertain positively, first that the injury really exists, and secondly that it is incurable. It is, however, equally obvious that the Workmen's Compensation Act, as it stands at present, although in many ways a very necessary piece of legislature, in other ways lends itself to a peculiar form of fraud which, if perpetrated under other circumstances, would lead to a criminal

prosecution. Finally, Sir John Hill calls attention to what, if true, is a very unpleasant matter. He says that there is a practice on the part of the speculative solicitor of agreeing with a medical man willing to accept such terms, that the latter shall receive remuneration in respect of his evidence, only if the award is in favour of the plaintiff. It is unnecessary, we hope, to point out that such an arrangement is contrary to all the ethics of the medical profession, that it is a temptation to men to give improper and incorrect evidence, and that any medical man who knowingly enters into it justly forfeits the respect of self-respecting persons.

### CURRENT TOPICS.

#### Destruction of Rats.

THE Society for the Destruction of Vermin has just held its first annual meeting, and the Chairman, Sir James Crichton-Browne, told of the work accomplished during the year. This work seems to have been chiefly of a missionary or educative kind, but he had to bemoan the fact that the interest taken in the subject was still of a theoretical rather than a practical character. There is no reason why this should be the case, if the information garnered by the Society is at all accurate, for, apart from the spreading of disease, it seems that each rat costs the country a matter of a farthing a day, and as there is a rat population of the density of one per acre, the total depredations of these lively rodents amounts to a sum of about £15,000,000 a year. Now, if this at all approximates the fact, it is easy to see that a commercial country like Great Britain would be greatly the gainer if dispossessed of their unwelcome intrusions. In these days of financial tightness at the Exchequer, a Chancellor who could devise some means of securing the total abolition of the pest should soon be able to surmount deficits of the most disconcerting nature without troubling anybody for an increased share of their wealth, whilst the most ardent advocates of a big Navy would have sufficient to provide themselves with a gigantic fleet without troubling the taxpayer at all. Unfortunately, we gather that the experience of the Society agrees with that of the Antipodes in finding that the bacteriological methods of decimation are not to be relied on in their present stage of evolution, though it may be thought that salvation lies in that direction. We are all against the rat in theory, but is it quite certain that if he were exterminated some worse thing might befall us?

### The Post Office and Re-vaccination.

MR. Buxton has allowed candidates for the Post Office service to be excused re-vaccination on joining, on making a statutory declaration that they conscientiously believe vaccination would be prejudicial to their health. No doubt he has been hardly pressed by faddists of the type of Mr. Lupton, but we cannot but consider that he has shown himself lamentably wanting in backbone in relaxing the regulation. The question is quite different from that of infantile primary vaccination. No one is compelled to join the postal service, and such

as do are persons of mature years and good health. We are sure that no candidate vaccinated secundum artem with glycerinised lymph has suffered more than the pangs which everybody suffers from this trivial operation, and the objection is a purely sentimental one excited and fanned by the crassly-stupid and crassly-ignorant. Moreover, the Post Office is a national distributing agency, and small-pox is undoubtedly capable of being disseminated by formites, so that in time of epidemicity of the disease, if the employees avail themselves at all largely of the relaxation, a considerable number would render themselves liable to contract it, and not only to contract it themselves, but to pass the infection broadcast through the community. It is regrettable that a man of Mr. Buxton's ability and character should so weakly yield to the obstreperous few because they make themselves a nuisance, when there is no real demand for the abolition of a salutary regulation designed to preserve the public health.

### Taxation of Births, Deaths, and Marriages.

Now that methods of "raising the wind" are exercising the minds of the community, and each class is shivering lest his be the henroost to be visited, the Daily Chronicle aptly reminds us that for eleven years, namely, from 1695 to 1706, births, deaths, and marriages were subject to taxation. The population was ranged into various grades of prosperity, and the tariff fixed accordingly. The duke figured at the top of the tree and the proletariat at the bottom, the doctor being regarded as the mean between the two. The birth of a duke's son rendered the parent liable to a fine of £30, a cook's son cost but 2s., while a similar offence on the part of a doctor produced £,1 2s. to the Exchequer. Marriage cost the respective parties £50, half-a-crown, and £5, while a duke had to pay £50 for the privilege of leaving the world, and the poorest subject had to find 2s. for following his example. Our contemporary adds: "One pities the poor doctor, who seems to have been held responsible for other people's births and deaths, as well as his own marriage." We agree, but it only shows that erroneous ideas about doctors' incomes is not a tree of modern growth only. We suggest that those who lament the fall in the birthrate should reverse the above process, and urge the State to pay a bounty to the doctor for each citizen he brings into the world.

### Insanitary Condition of Irish Schools.

We referred recently to the shocking condition in which many of the primary schools in Ireland are kept. The same subject has engaged the attention of the Council of the Dublin Sanitary Association, who have passed a resolution that no adequate and permanent improvement can be expected until the system of medical inspection of school children recently adopted in England be extended to Ireland. We know of no reason why the Act was limited to England, and we trust that in the near future a similar measure can be made to apply to Ireland. But in the meantime we believe that much could be done to improve matters. Even without the medical inspection of children, the condition of the school buildings could be remedied. We believe that it is

within the power of the Board of National Education to refuse to recognise schools which are not housed in proper buildings. If this were done, many of the dens at present in use would be closed. We repeat, without hesitation, that it would be better that children should remain without education than that they should be forced to congregate in hovels which breed disease, and where they learn to be accustomed to, and to tolerate, fifthy conditions.

Remuneration of Surgeons and of Veterinary Surgeons.

A curious contrast, indicating, we may believe, the relative value put on their services by the public, was brought out by Mr. Gladstone the other day, in stating the remuneration paid under analogous circumstances to medical men and to veterinary surgeons respectively. In answer to a question as to the fees paid by the Home Office through the police for attending casualties in the streets, it was stated by the Home Secretary that the fee paid to a medical man was three shillings and sixpence, whereas the fee paid to a veterinary surgeon was ten shillings and sixpence. It would seem, therefore, that one veterinary surgeon is valued as equal to three medical men, or is it that one horse is worth three men? Moreover, Mr. Gladstone was of opinion that the medical men in question received "adequate remuneration." We do not blame Mr. Gladstone or the Home Office authorities. They naturally pay the smallest fee for which they can obtain the services required. If it pays medical men to take such work there is no more to be said. It is, however, an instructive example of the results of the overcrowding of the profession. We would strongly advise intending medical students to turn their attention to veterinary medicine. They will receive better remuneration, and doubtless also be esteemed more highly in the community.

Consent to Operation.

THE Supreme Court at Leipzig has laid down that a surgeon who operates on a patient without the patient's consent or the consent of the patient's legal guardian commits the crime of inflicting bodily harm. The case in which this ruling was given was one in which a surgeon at a Berlin hospital operated on a child without asking the permission of the parents, or notifying them that an operation was going to be performed. This judgment establishes a precedent which settles the question as far as Germany is concerned. Moreover, it has been held that an operation performed without the consent of the patient or the patient's legal guardians is wilful bodily injury, an offence which is punishable by imprisonment. The Supreme Court has ruled that in a case where a surgeon operates without permission, being under the impression that consent has been given, he is also guilty of bodily injury, but that extenuating circumstances may be granted to him on the ground of good faith. Of course it is proper that parents or guardians should be consulted as to operations. but in case of emergency, when a surgeon has to act on his own judgment without such consent, the position is very serious in the light of this We, in England, happily, have not ruling. reached this pitch of legal inelasticity.

Bakers and Bad Eggs.

From time to time accounts are published of the prosecution of a baker having on his premises eggs unfit for human consumption. It is a curious fact that, however had the eggs, the pastry in which they have been incorporated shows little or no trace of their undesirable presence. Presumably the volatile products of putrefaction have been driven off by the heat of the oven; what remains of the albuminous substance is at the same time coagulated, and it is to be presumed that the majority of the bacteria present are incontinently destroyed, otherwise the effects of introducing such pestilential stuff into the human stomach might be disastrous. It may be remembered, however, in this connection that among the Chinese the rotten egg is esteemed a luxury, and forms a bonne bouche of which the Western visitor is expected to partake when invited to dine at the house of a mandarin. But whatever the ultimate scientific finding of the laboratory may be with regard to the precise hygienic position of rotten eggs as an article of food, the average citizen of the Western sphere will heartily endorse the action of the London magistrate who, in a case of the kind recently brought before him, remarked it was a mercy the sanitary inspector went into the bakehouse, and fined the culprit £15 and costs. Unhappily for the future welfare of the cakeconsuming public, the worse the eggs the better the glaze that can be made therefrom.

### PERSONAL.

THE PRINCE AND PRINCESS OF WALES paid a surprise visit to the Middlesex Hospital on March 22nd, and spent two hours in the institution. Their Royal Highnesses, who were accompanied by Prince Francis of Teck, one of the vice-presidents of the hospital, were conducted over the institution by the secretary-superintendent, the lady-superintendent, and the resident medical officer. A visit was made to the Cancer Research Laboratories, where the Prince and Princess showed great interest in the researches—especially those in connection with radio-activity in cancer, the lines of which were explained to them by the director, Dr. Lazarus-Barlow.

PRINCESS VICTORIA OF SCHLESWIG-HOLSTEIN opened the annual exhibition of the Royal Amateur Art Society, at 16 Grosvenor Place, on March 25th. The proceeds of the exhibition will be devoted to the East London Nursing Society and other charities.

THE DUKE OF WELLINGTON presided at the annual meeting of the Brompton Consumption Hospital on March 19th. Lord Cheylesmore moved the adoption of the report for 1908, which shows an increase in the grants to the hospital from the King's Fund and the Hospital Sunday Fund of £3,500 and £3,420 respectively. The committee regard this as in a large measure due to the remarkable success which continues to result from the special form of treatment by graduated exercises carried out at the Frimley Sanatorium

GENERAL SIR J. RAMSAY SLADE, R.A., has been elected chairman of the Committee of Management of the Italian Hospital, Queen Square, W.C.

Surgeon-General George D. Bourke, C.B., has been appointed an honorary physician to the King, vice Surgeon-General T. Tarrant, C.B., deceased.

MAJOR RONALD Ross, C.B., F.R.S., returned last week from an important mission to India, on which he was sent by the Liverpool School of Tropical Medicine.

THE new out-patient department of the Royal Boscombe and West Hants Hospital will be opened by H.R.H. the Duchess of Albany on Saturday, April 3rd.

DR.: SAMUEL GREFITH, M.D., of Bodlondeb, Portmadoc, a prominent Freemason, who died on 1st December, aged 77, left estate of the gross value of £10,161, with net personalty £4,903.

DR. G. F. BUCHAN, M.B., D.P.H., Deputy Medical Officer for the city of Birmingham, has been appointed medical officer of health for the district of Heston and Isleworth, Middlesex, in succession to Dr. E. Steegman.

AMID cheers from both sides, the Ottawa House of Commons last week unanimously accepted a gift of £50,000 from Lord Strathcona for the furtherance of the scheme for the physical training of the school children of Canada. The annual sum to be devoted to this purpose is £2,000.

Dr. Bonnje. Senior Medical Officer of the Russian Squadron which was entertained last week in London by the Admiralty, and seven other Russian medical officers lunched with Inspector-General T. D. Gimlette and the officers of Haslar Hospital on March 17th. The Russian officers were afterwards shown over the hospital.

THE Mayor of Marylebone (Colonel Alderman A. J. Hopkins) presided, on March 22nd, over the annual meeting of the Marylebone Health Society, held in the Town Hall. Dr. Meredith Young, Medical Officer of Health of the borough, and Dr. A. Newsholme, Medical Officer of the Local Government Board, were among the speakers.

THE annual council of governors of the Great Northern Central Hospital was held on March 18th, under the presidency of Sir John Dickson-Poynder, M.P. (chairman of the committee of management). The Chairman stated that there was a deficiency on the past year of £4,643, and at the present time an indebtedness to the bankers of £10,304.

THE eighth International Congress of Hydrology and Climatology, including geology and physical therapeutics, will be held this year at Algiers, from April 4th to 10th, under the patronage of the Governor-General of Algeria. The local secretaries for Great Britain are Dr. G. Pernet and Dr. Purves Stewart, 94 Harley Street, London, W.

THE 136th Anniversary Dinner of the Medical Society of London was held on March 10th at the Hôtel Métropole, under the chairmanship of Mr. C. B. Lockwood, F.R.C.S., the President of the Society for the current year. Among the speakers were Sir William Church, President of the Royal Society of Medicine, Sir Alfred Keogh, and Dr. J. Kingston Fowler.

THE Northumberland and Durham Medical Society held their annual dinner on March 18th, at the Royal Turk's Head Hotel, Newcastle, when Dr. R. S. Peart (President) was in the chair, and the principal guest was Sir Lauder Brunton, Bart., F.R.S. Among others present were the Lord Mayor of Newcastle (Ald. J. J. Forster), Prof. Sir George Hare Philipson, Prof. Sir Thomas Oliver, and Dr. G. H. Hume.

THE West African Section of the London Chamber of Commerce gave a complimentary dinner at the Criterion Restaurant on March 18th to Professor W. J. H. Simpson, M.D., F.R.C.P., on his return from West Africa after his investigations, on behalf of the Colonial Office, into the existence of plague and the sanitary measures in force there. Sir Ralph Moor, Chairman of the Section, presided, and the company included Mr. Charles Charleton, Sir William Church, Sir Patrick Manson, F.R.S., Sir Shirley Murphy, and Sir Roper Parkington.

### A CLINICAL LECTURE

ON THE

# TREATMENT OF LOCAL TUBERCULOUS LESIONS BY INJECTIONS.

By Prof. A. CALOT, M.D.,

Physician to the Berek Institution, Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

EXTERNAL localisations of tuberculosis are, by common accord, amenable to three kinds of treatment: operative, expectant, and by injections, and there are many reasons for asserting that the lastnamed is far and away the best. Operation is to be discarded, for it rarely effects a cure and it is always very disfiguring. The conservative treatment without injections is, on the whole, preferable to operation, but it is too uncertain; it yields unsatisfactory results in half the cases, and it is too protracted, since it takes from three to five years.

The treatment by injections, on the contrary, always, or almost always, effects a cure (in 99 per cent, of the cases), and this in a comparatively short space of time—a few months at the outside—and it leaves no disfigurement. Moreover—and this is no small advantage—it is benign, easy of execution, and can be carried out by anyone.

In order to yield these highly satisfactory results, however, the treatment must be applied sec. art. It must be done in a particular way and in no other; we must employ a particular medicated solution and no other, in prescribed doses, the injections to be made at stated intervals, and so on.

If it be done anyhow, the result will probably be disappointing so I will now describe the technique.

disappointing, so I will now describe the technique.

Instruments.—Three instruments only are necessary: (1) Needles, a series of four, corresponding to Colin's Nos. 1, 2, 3 and 4. Nos. 1 and 2 are used for injections without previous puncture, that is to say, in dry tuberculosis. Nos. 3 and 4 are used in cases in which injection is preceded by puncture—i.e., in suppurating tuberculosis. (2) An aspirating syringe. (3) A sterilisable syringe of any kind. We may add a tube of chloride of ethyl for local anæsthesia.

The Fluid for Injection.—There are numerous formulæ for this, but the two following will suffice for all cases.

The first is a mixture of iodoformic ether and creosoted oil in the following proportions:—

Liquid vaseline, 75 grammes; Ether, 25 grammes;

Creosote, 5 grammes; Iodoform, 10 grammes.

The second is a mixture of camphorated naphthol and glycerine:—

Glycerine, 15 grammes;

Camphorated naphthol, 3 grammes.

The latter requires to be beaten up in a mortar or well shaken for a minute or two, so as to make a homogeneous fluid, miscible with water. We must make sure of this before each injection by allowing a drop to fall into water. If the drop does not disappear in the water, some more glycerine must be added and the mixture again shaken up. Chemists dispense camphorated naphthol more or less clear, so that the quantity of glycerine required varies somewhat.

The indications for one or other of these formulæ may be deduced from the fact that the first is sclerosing, while the second is resolvent. Conse-

quently, when the lesion is suppurating and the abscess is quite ripe, we make use of the first, while, if the abscess is not ripe, or if the liquefaction of the granulations is only partial, we make use of the second, which will precipitate the liquefaction, though even in this case we wind up by one or two injections of the creosote-iodoform mixture.

The Dose.—The dose of either mixture is from 2 to 12 grammes, according to the patient's age, and, to some extent, to the size of the tuberculous focus. About ten injections are usually necessary, given at intervals of four or five days, as a rule. The injections should be made into the tuberculous focus, and not in the neighbourhood.

We will take a case of suppurating tuberculosis, a cold abscess, a softened cutaneous gumma, a suppurating adenitis, a synovitis, cr a white tumour with effusion, a congestive abscess, no matter. We must evacuate some of the fluid before making the injection. For this purpose we make use of a No. 4 needle, which is connected up with the aspirator. When we have completely emptied the abscess the aspirator is disconnected, and the needle, which has been left in situ, is adapted to the syringe containing the fluid for injection.

Two observations may here be made—viz., that it is not always advisable to make an injection directly after evacuation of the abscess contents. For instance, if the skin over the abscess is much stretched, it is undesirable to inject at once, since we should run the risk of further damaging the skin. In such cases it is preferable to repeat the punctures at short intervals, say, every two days, or even daily, should that appear necessary, to prevent the skin giving way under the eccentric pressure of the contained fluid. The puncture is made in a different spot each time in order to damage the skin as little as possible. As soon as the skin has recovered tone, we proceed with the injections to the number of ten.

The second observation is, that at the end of the course, after the tenth injection, we must make two punctures at stated intervals, not followed by any injection. At this stage the abscess wall is only secreting a non-virulent serum, but this secretion might go on indefinitely if we continued injecting the modifying fluid, which is always more or less registing.

less rrritating.

In order to dry up the secretion, it is well at the end of the treatment to apply methodical pressure by pads of cotton wool and crêpe bandages, hoping by this means to bring the abscess walls into apposition. When the tuberculous lesion is dry or fungous, as in a cutaneous tuberculome, a hard gland, an epididymitis, a fungous arthritis, &c., our object is either to effect a sclerous transformation of the granulating tissue or its liquefaction.

To determine sclerosic, we inject the mixture of creosoted iodoformic oil in doses of from 2 to 8 grammes, according as the patient is a child or an adult. The injection is made into the centre of the fungating mass, and is repeated every three or four

days until ten have been given. Then the region is compressed with pads of cotton maintained by a crêpe bandage.

It is to be borne in mind that the desired sclerosis does not take place either during or immediately after the injections. On the contrary, the glands injected remain swollen, and it is not until three or four weeks after the last injection that they begin to diminish in size, and they do not quite disappear for from three to five months.

When we wish to bring about liquefaction of the contents we inject the mixture of camphorated naphthol and glycerine in doses of from 1 to 5 grammes, according to the age of the subject. In this particular case we must repeat the injection daily until the gland has broken down. By the fourth and sixth day some elasticity or even fluctuation may be perceived at the centre of the tumour, a sign that liquefaction is taking place. As soon as that is the case we puncture, and then inject; but thenceforth we need only make two injections a week until ten injections have been made (from the time of the liquefaction).

Which are we to aim at, sclerosis or liquefaction? Well, speaking generally, liquefaction is preferable, for the cure is more certain and more radical. On the other hand, the reaction to the resolvent injections of camphorated naphthol is sometimes rather intense and distressing, so that for patients who are not in a hurry, and in private practice, I advise recourse to injections of creosoted iodoformic oil, which suffice in 75 per cent. of the cases. Should it prove otherwise, we can always fly to the cam-

phorated naphthol as a last resource. There is always—and there ought to be—a certain reaction whichever fluid we employ, but this reaction is much more pronounced with camphorated naphthol, especially when we have to repeat the injection daily. This reaction does not immediately follow the injection, and is manifested by general and local symptoms of ordinary subacute inflammation, a sort of "tepid abscess," so to speak. The temperature may go up to 990, 1010, or even 1020 F., with the doses recommended above. It is possible, however, to control this reaction without sacrificing the effects we wish to obtain-viz., the liquefaction.

If, after the first or second injection, the temperature goes up it is a good sign, in that it indicates a speedy action, but the pain and other symptoms must not be allowed to go beyond a certain measure, nor the temperature allowed to remain for more than a few days at 1030 F. With this object in view, we only have to suspend the injections for a day or two, or else inject somewhat smaller quantities. Still, it must be borne in mind that a certain reaction is indispensable, and we must aim at obtaining what is required, and no more.

The Technique for Special Organs.—The instructions enumerated above are applicable in general to external tuberculous lesions, wherever situated. We will now discuss their application in sundry special cases: enlarged cervical glands, tuberculosis of the testicle, and of the epididymis. We shall then add a few remarks on the anatomical facts that must guide us in injecting joints and congestive abscesses in Pott's disease.

Cervical Adenitis.-These should never be extirpated, for here, more than elsewhere, surgical intervention leaves disfiguring scars without affording any security against recurrence. If the gland has broken down, it is dealt with by puncture, as described above, and a cure can be obtained in six or eight weeks without any scarring. If the gland be hard it is preferable to cause it to break down. with which object in view we inject daily into the centre of the gland 20 drops of the naphthol solution. By the fifth day there will be fluctuation, whereupon we proceed with the punctures and injections at intervals, just as in the case of spontaneous suppuration.

Tuberculosis of the Testicle and Epididymis.— Here again operative intervention gives disastrous results; it rarely cures and always mutilates, and what mutilation! Early in my professional career I used to operate, but for the last fourteen years I have altogether abandoned castration, and have had recourse exclusively to injections. Out of 116 cases in children and adults I have not to record a single instance of failure. These statistics comprise not only cases of testicular and closed epididymal tuberculosis, but also many fistulous cases to the extent of a fifth of the total number. The cure took from two to four months for unopened lesions, and from three to ten months for the others.

Just as in the case of tuberculous glands, we have to choose between sclerosis and breaking down, but on account of the peculiar susceptibility of the integument, and especially when we are dealing with lesions close to the skin, I advise the sclerosing treatment (creosoted iodoformic oil) in preference to the naphthol solution, which causes liquefaction. If suppuration has taken place we have recourse to

punctures and injections, as for glands.

There is a third group of cases in which hydrocele is symptomatic of tuberculous lesions of the testicle or epididymis, and in these we must make the injections and punctures right into the tunica vaginalis itself, as if we were dealing with an ordinary cold abscess. In five cases out of seven we have effected a cure by this treatment of tuberculosis of the neighbouring epididymis without attacking it directly. In the two other cases we had to inject the epididymis directly, and this proved successful.

Intra-articular Injections.—Not only articular tuberculosis, but all forms of arthritis or osteoarthritis, whether rheumatic, gouty, blennorrhagic, dry arthritis, &c., are amenable to intra-articular injections, the solution varying according to the nature of the lesion. It is therefore indispensable to be quite familiar with the puncture points for

each joint.

Upper Limb.—The shoulder is attacked from the front, taking the coracoid process as our guide. The bony prominence is easily identified, even in stout subjects, below the outer fourth of the clavicle. It forms the antero-external angle of the bony arch of the shoulder (acromio-coracoid arch). The needle is thrust in at a spot a third of an inch outside this process, from before backwards and slightly from above downwards, pushing the needle until it meets with bone. This is the head of the humerus covered with its cartilage, and we know that we are inside the joint cavity. We have only to withdraw the needle a trifle before making the injection.

The Elbow.—This joint may be entered from outside or from behind—i.e., through the humeroradial interline, to be felt at the external border of the elbow, while the forearm is being rotated, or well above the tip of the olecranon over the subtricipital cul-de-sac of the synovial membrane of the joint. The latter plan is to be preferred, since it gives us more room.

The tricipital cul-de-sac is readily accessible, especially when the forearm is flexed. We have only to thrust the needle in a third of an inch above the tip of the olecranon in the middle line, pushing it in until we meet with bone, when we know that

we have entered the cavity.

The Wrist.—It is not quite so easy in the wrist, but it can be effected with certainty if due care be taken to conform to the directions. The joint must be attacked from behind. The middle of the interline is a quarter of an inch above the middle of a line drawn between the two styloid processes of the ulna and radius, which are always easy to recognise. The needle is then pushed in a quarter of an inch above this line, using a fine needle, the patient's hand being strongly flexed so as to open the intervening space. In arthritis of the wrist, synovial pouches are often visible on the back of the wrist, and all we have to do is to insert the needle into one of these prolongations.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by James Sherren, F.R.C.S., Assistant Surgeon to the London Hospital, Surgeon to the Poplar Hospital for Accidents. Subject: "Duodenal Ulcer, its Diagnosis and Surgical Treatment."

### ORIGINAL PAPERS.

### DEATH CERTIFICATION AND CORONERS' INQUESTS.

By FREDERICK W. LOWNDES,

Surgeon to the Liverpool Police.

Two Acts of Parliament, the Births and Deaths Registration Act of 1874, and the Coroners' Act, 1887, have been very prominently before the medical profession and the public for some years past, and especially during this present year. The first of these Acts made the certification of deaths compulsory on all medical practitioners attending patients in their last illness. The 20th clause of this Act is as follows:-

"In case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign and give to some person required by this Act to give information concerning the death, a certificate stating, to the best of his knowledge and belief, the cause of death, and such person shall, upon giving information concerning the death, or giving notice of the death, deliver the certificate to the registrar, and the cause of death as stated in the certificate shall be entered in the register, together with the name of the certifying medical practitioner.

Before this Act was passed and became law on the 1st January, 1875, certificates were given, a refusal to give one generally leading to police inquiries, and the reporting of the case to the coroner of the district. This giving of certificates has always been an unpaid and most thankless duty. The clause of the Act of 1874 which I have given is most important for many reasons, and should be well known to every practitioner whom it concerns, from house surgeons or physicians to the oldest and most experienced practitioner. It will be seen that it protects every medical practitioner from giving a certificate of the cause of death unless he has attended the deceased (presumably for a reasonable interval before the death), and also that the death is one from natural causes, and one which the registrar can register without hesitation. Every practitioner who gives a certificate of the cause of death should remember the old saying, "Litera scripta manet," and that his name will be indelibly recorded in the register. It was not so before this Act was passed, and it is a remarkable coincidence that in the last edition of the late Dr. Taylor's

manual on "Poisons" I find the following sentence: "Gastric fever." It could scarcely be supposed that a case of antimonial or of arsenical poisoning should be mistaken for this disease. The case of Mary Ann Cotton (Reg. v. Cotton, Durham Lent Assizes, 1873) shows, however, that such a mistake may be made, not only in one, but in a series of suspicious cases. One out of three husbands and four of her children died rather rapidly one after another, with symptoms of irritant poisoning, proved by the exhumation and examination of their bodies to be owing to arsenic. Gastric fever was certified by the medical man to be the cause of death. Under such a perfunctory mode of registering causes of death, it is not surprising that this woman succeeded in destroying by poison twenty persons before her crime was discovered. Though thirty-four years have passed since the conviction and execution of this wretched murderess, I remember well the sensation it caused. Her victims comprised three husbands, fifteen children, her mother, and a lodger. She had married a fourth husband, who found out that she had insured his life behind his back, and decided to leave her. It is a terrible and, I hope, a unique instance of a woman marrying husbands and bearing children, only to poison them for the most sordid of motives.

Thirteen years later the Coroners' Act was passed, receiving the Royal assent 16th September, 1887, and at once becoming law. It repealed many very ancient statutes, including one of 1 Edward III., stat. 1, c. 8. This required the coroner to go to the place where any be slain, or suddenly dead or wounded, to summon a jury, and to inquire as to the cause of death. Acting upon this, coroners claimed the right to hold an inquest in any and every case of sudden death, though its cause was perfectly well known to the relatives and medical attendant. The 3rd section of the Act now in force defines, with some approach to perfect accuracy, the deaths which should form the subject of an inquest. It, as well as the 20th clause of the Registration Act of 1874, should be well known and carefully studied by every medical practitioner, to learn when he can give a certificate of the cause of death, and when he ought to refer the cause to the coroner.

"When a coroner is informed that the dead body of a person is lying within his 'jurisdiction,' and there is reasonable cause to suspect that such person has died a violent or an unnatural death, or has died a sudden death of which the cause is unknown, or that such person has died in prison, or in such place or under such circumstances as to require an inquest in pursuance of any Act, the coroner, whether the cause of death arise within his jurisdiction or not, shall, as soon as practicable, issue his warrant for summoning not less than twelve or more than twenty-three good and lawful men to appear before him at a specified time and place, there to inquire, as jurors, touching the death of

such person as aforesaid."

Now, a coroner's court has been called one of "first instance," and it is very important he should be informed promptly of every death comprised within the section just quoted. Sudden deaths are followed by rapid decomposition, especially in hot weather; so are violent or unnatural deaths occurring under similar circumstances. Hence the importance of his being informed of each of these by him who alone is competent to give a correct opinion-the medical attendant in the last illness, or who has first seen the body after death. For a violent death includes one in which death may not have occurred till a long time after the violence. A legal tradition gives one year and one day as a limit. But this is a matter for the coroner to

decide, it being for him to judge what is "reasonable cause to suspect," etc.

In sudden deaths of which the cause is well known to the medical attendant of the deceased as being due to natural causes, such as heart disease, apoplexy, epilepsy, Bright's disease, diabetes, etc., he can inform the coroner and so avoid the necessity for an inquest. For although this important section does not make it compulsory on the medical attendant to inform the coroner of the death and of its cause, it is very desirable that he should do so, and that all medical practitioners should work with the coroner and not against him. Reference to a coroner does not mean that an inquest must follow, since he has power to make an informal inquiry, and may send to the registrar what he believes to be the cause of death. For although the vagaries of some coroners have of late been such as to revive the old taunt of "crowner's quest law," yet it must in justice be admitted that coroners have reason to complain of the carelessness of some medical men in giving certificates contrary to the law as defined by the two Acts before us. A very gross instance of this occurred towards the close of 1891. A woman named Matilda Clover, belonging to the unfortunate class, died in a brothel in London. A man named Neill or Cream had accompanied her home and passed some hours with her. He was heard to bid her good-bye and to leave the house. Some hours after she was heard screaming, and was found to be in violent convulsions and in great agony, in which she died. No registered practitioner saw her till after her death, when a surgeon who had attended her some time previously for intemperance came at the request of the brothel-keeper and saw the dead body. He filled up the usual form of certificate, stating that he last saw her when he saw not her but the dead body. He gave the cause of death as chronic alcoholism, the symptoms being totally different. One mistake often leads to another, and so it was here. The brothel-keeper registered the death, informing the registrar that she was present at the death, which was false. The registrar registered the death, instead of reporting it to the coroner as it was an unnatural death. Only a week previously another prostitute had been poisoned by strychnine by the same man, and the police were in search of him. Six months later two more prostitutes were poisoned by the same man with the same poison. The body of Matilda Clover was exhumed and examined, strychnine being found. Had the surgeon who certified to her death as due to chronic alcoholism refused to certify at all, and informed the police, he would have been instrumental in arresting the career of this murderer and, humanely speaking, he might have saved the lives of two other women. It is satisfactory to record that in three out of the four cases the cause of death was promptly and correctly diagnosed, and after a long trial the murderer was executed. This case attracted much excitement, and our registration system was condemned, but unjustly so. not the system, but the conduct of all the three persons who acted in violation of what was the plain duty of each.

A Select Committee of the House of Commons was appointed in 1893, under the chairmanship of Sir B. Walter Foster, then Secretary to the Local Government Board, to inquire into the sufficiency of existing law as to the disposal of the dead, for securing an accurate record of the causes of death in all cases, and especially for detecting them where death may have been due to poison, violence, or criminal neglect. Sir Walter Foster was aided by very able colleagues; witnesses of the highest stand-

ing in the medical profession attended to give evidence. The inquiry was a most exhaustive one, and the Bluebook containing their report, with the minutes of evidence, can be obtained for a very small sum, and will well repay perusal. Their principal recommendations were:—

That no death should be registered without a medical certificate or by a coroner after inquest.

That medical practitioners should verify the death of each person whose death they certify.

That the same form shall be used by every medical practitioner.

That the practice of burial in pits or common graves should be discontinued.

That still-births which have reached the development of seven months should be registered.

Fifteen long years have passed since these recommendations were made and others which I have been obliged to omit, but nothing has been done except two alterations in the form of medical certicate furnished by the Registrar-General. has now a letter and number, and so can be traced. Each has the word "alive" printed after "I last saw h——." It must be humiliating to the overwhelming majority of the medical profession that it should be necessary for any member to be taught that a dead body and a living person are not identical. A Bill has been drafted, and may become law during the present session of Parliament, to abolish the compulsory viewing of dead bodies by coroners' juries. If one may judge from reports of inquests in the daily press, the abolition of coroners' juries altogether would be a welcome change. Any member of the House of Commons who would bring in such a Bill and carry it successfully through, would earn the lasting gratitude of the thousands of men who now have to leave their occupation and spend hours and days at inquests to perform a most disagreeable and wholly unnecessary duty. There is no coroner's jury in Scotland; the procurator-fiscal makes his inquiry with the aid of the medical attendant or some other surgeon, gives his order for the burial, and the utter farce of twelve good and loyal men to decide what can be done by one is dispensed with. That it is not per-fect may be admitted. The Ardlamont and Carlisle poisoning cases show this. But our adoption of it in England and Wales, with such modifications as might suggest themselves, might well be considered. The Births and Deaths Registration Act ought to be amended to make it harmonise with the Coroners' Act. This also requires amendment to suit the requirements of the medical profession, who justly demand remuneration from the coroner for information given which makes an inquest unnecessary, also for attendance at adjourned in-quests, and more liberal fees for attendance and necropsies.

# PROGNOSIS IN VALVULAR DISEASE OF THE HEART. (a)

BY SIR JOHN F. H. BROADBENT, BART., M.D., F.R.C.P.,

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THE subject of prognosis in heart disease is one of the first importance to both physician and patient. The latter will wish to know not merely whether he is in danger of sudden death, but what are his prospects as to the future, and how best he may regulate his mode of life, exercise, diet, etc., so as to give himself the best possible chance. The physician is required, therefore, not merely to make an accurate

(a) Bend before the Section of Medicine in the Reyal Academy of Medicine in Ireland, Friday, February 28th; 1909.

diagnosis of the nature of the affection, but to forecast what effect it is likely to have in shortening the patient's life, and in limiting the sphere of his To do this he must have a clear idea as to the relative danger attending the various valvular lesions, and also some method of estimating the extent of the lesion.

In 1884 my late father delivered before the Harveian Society the Harveian Lectures on "Prognosis in Val-vular Disease of the Heart," in which he laid down certain rules for guidance in prognosis, based on the structural changes in the heart and vascular system, which take place as a result of the lesion, pointing out how an approximate estimation of the extent of the lesion could be arrived at from the degree of structural change to which it had given rise.

There are, of course, many other points which must be taken into consideration, such as the age and family history of the patient, the ætiology of the lesion, whether due to acute endocarditis or chronic degenerative change, the character of the murmur, and the degree to which it replaces the sound it accompanies, etc. These will be dealt with seriatim in the discussion on the different valvular lesions.

Reserve Power of the Heart.—In the healthy heart

there is an enormous reserve power which enables it to respond to the increased demands entailed by exertion and exercise without any ill effect. This reserve power is diminished if one of the valves be damaged, even though compensation has taken place, in proportion to the extent of the valvular lesion. If the heart be taxed beyond the limit of its reserve, warning symptoms, such as dyspnœa, etc., will set in, and if the exertion be persisted in in spite of these, breakdown of compensation and serious damage to the heart may result.

AORTIC INCOMPETENCE.

In discussing the question of prognosis in aortic incompetence, we must draw a sharp line between that which results from acute endocarditis in the young, and that which is due to degenerative changes which affect the root of the aorta or its valves in later life. In the former, a lesion once established does not increase in severity, but the cicatricial con-traction which occurs in the process of repair will tend rather to limit than increase the incompetence. In the latter the incompetence is commonly due to dilatation of the root of the aorta, to which the valves are attached, from weakening of its wall by athero-matous degeneration, and this is likely to be pro-

We will now consider for a moment the consequences of aortic incompetence. Immediately after the closure of the semi-lunar valves the elastic recoil of the aorta drives back into the ventricle an amount of blood which will vary in proportion to the degree of incompetence of the valves. The ventricle is in diastole, and blood is being poured into it from the left auricle; in addition to this, blood is forced back into it under pressure from the aorta. In its relaxed condition it is unable to resist the over-distension, which is a consequence, and it gives way under the strain and dilates. As it has to propel a greater volume of blood, and resist, as far as possible, excessive distension by the regurgitant stream, it is essential that its walls should be strengthened, and we find that under favourable circumstances hypertrophy of the left ventricle, in process of time, takes place.

The degree of hypertrophy is, as a rule, proportionate to the degree of incompetence, and in prognosis is of great importance as one of the means of esti-mating the extent of the lesion. Certain qualifications

are, however, necessary.

(1) In the first place, in this, as in all cases of endocarditis due to rheumatism, we must bear in mind that it is not the valves alone which suffer, but that the heart muscle seldom escapes damage. In proportion to the degree of myocarditis, there is loss of tonicity of the heart muscle, and a corresponding ten-dency to dilatation, which may be extreme even in the absence of a valvular lesion, as we see in some cases of pericarditis. If, therefore, we have in addition to an aortic lesion a severe degree of myocarditis, the initial dilatation may be out of all proportion to

the degree of incompetence, as will also be the hyper-

trophy that ensues if a patient recovers.
(2) If the patient gets up too soon and goes about before sufficient time has elapsed for the structural changes necessary for compensation to take place, the degree of dilatation and hypertrophy which ensue may be out of proportion to the lesion.

(3) If the patient has passed the age of adolescence when the lesion occurs, it is improbable that the requisite degree of hypertrophy will ensue, as regeneration of muscular tissue does not occur to any extent in later life.

The Pulse.-The most remarkable feature in the pulse is the collapsing character, to which attention was first drawn by Corrigan, due to the loss of sup-port to the column of blood in the aorta on its elastic recoil, and consequent sudden fall of pressure en-tailed by the leakage through the incompetent valves. This is more marked when the arm is held in the vertical position. It is proportionate to degree of incompetence of the valves, and hence constitutes an important criterion in prognosis as one of the indica-tions of the extent of the lesion. The large size of the arteries and relaxed condition of the arterioles are also remarkable, and it would appear that this is a protective measure against overstrain by the increased volume and greater force with which the blood is projected by the hypertrophied and enlarged heart into the arterial system. The size of the artery,

therefore, is of important prognostic significance.

The Symptoms.—The symptoms are mainly those of deficient blood supply in the systemic circulation consequent on the ill-sustained blood pressure. Pallor of countenance, a tendency to faintness on suddenly assuming the erect from the recumbent position, dyspnæa, præcordial pain and oppression on exertion, and, it may be, anginoid pains are among those most frequently met with. The readiness with which they set in on slight exertion, and the degree of severity, must be taken into account in prognosis. When compensation is perfect, as may be the case in moderate lesions, they will not be much in evidence, but they are often the first danger signals in cases of old standing, premonitory of failing compensation.

Other points to be taken into consideration are:—
(1) The age of the patient at the time the lesion is established. This is of the utmost importance. If it occurs in youth, there is every chance of satisfactory compensation being established, but if it occurs in middle or later life, even as a result of acute endocarditis, there is little chance of the left ventricle responding to the call for the hypertrophy which is essential. The usual sequela in these cases and those of great severity in the young is extreme dilatation of the left ventricle, with secondary mitral incompetence, followed by complete failure of compensation and back working through the lungs. The right ventricle, being unequal to the demand upon it, breaks down,

and enlargement of the liver and dropsy, etc., ensues.
(2) The Murmur.—This may be loud or soft, long. or short. Sometimes it is inaudible at the aortic cartilage, but heard distinctly over the sternum to the left at the level of the third or fourth left costal cartilages. Speaking generally, a long, loud murmur indicates that the heart is acting vigorously, and that the leakage is not great, and is therefore of favourable prognostic significance. A weak, short murmur, replacing to a great extent the second sound, indicating the oppositestate of things, is necessarily of unfavourable augury.

(3) The Second Sound .- In moderate degrees of incompetence this is not replaced to any extent by the murmur. It is not always possible to be certain in listening over the aortic area that the second sound we hear there is not the pulmonic conducted across, but there can be no such doubt when we listen over the carotid in the neck. If the second sound is audible here, we can be sure that it is not replaced toany extent by the murmur, and it is therefore a

any extent by the murmur, and it is therefore a favourable element in prognosis.

The Aortic Incompetence of Later Life.—This is usually the result of chronic degenerative change, affecting not only the valves, but the aorta. Frequently dilatation of the root of the aorta, to which the valves are attached, is the primary lesion and the

main cause of the incompetence. The character of the aortic second sound in these cases is pathognomonic. It is, as a rule, low-pitched, loud and booming. This is quite distinct from simple accentuation, and is indi-cative of dilatation of the aorta. The diastolic murmur does not replace the sound to any extent, and may be inaudible at the aortic cartilage, but heard distinctly along the left border of the sternum at the level of the third or fourth aortal cartilage. The degree of incompetence is seldom very great, but is liable to be progressive from the nature of the changes in the aorta which have given rise to it. If at all severe, the left ventricle is, as a rule, unable to respond to the extra strain, and soon breaks down, with resulting secondary mitral incompetence, back working through the lungs, etc. The incompetence of the valves, however, may be the least serious of the danger with the strain. dangers which threaten the patient. In three instances I have seen aneurysm of the ascending aorta develop in cases which, when they first came under observation, presented only the physical signs of aortic incompetence and slight dilatation of the aorta. Degenerative changes in the heart wall, atheroma of the coronary arteries with resulting symptoms of angina, sclerosis of the renal vessels giving rise to uramic symptoms, are also possible sources of danger which we must bear in mind when we attempt to forecast the future in these cases.

AORTIC STENOSIS.

The effect of aortic stenosis is to diminish the size of the blood stream flowing from the heart into the aorta, and to throw extra work on the left ventricle, which has to use greater force to overcome the obstruction. Consequently the degree of hypertrophy of the left ventricle will be one of the most trustworthy indications of the degree of obstruction. As the calibre of the arteries is reduced in proportion to the size of the blood stream the size of the radial artery will be a further important clue to the degree of stenosis. These, being the two main guides as to the degree of severity of the lesion, are the two most important considerations in prognosis. They are also important in aviging of the degree of severity of the lesion, are the two most important in aviging of the degree of the second severity of the second s important in arriving at a diagnosis, as there are many varieties of systolic murmur heard at the aortic cartilage which do not indicate stenosis of the aortic orifice, and in later life a rough systolic murmur is frequently met with, due to some rigidity or degenerative changes in the aortic valves which do not cause actual stenosis. Time will not, however, permit of my discussing the differential diagnosis of these aortic systolic murmurs. Pure acrtic stenosis is not very common, and it is difficult to imagine how it can exist without some incompetence, but is more frequently met with in combination with aortic regurgitation, when the modification in the character of the pulse which it entails is of great diagnostic value. In my experience it is one of the least serious of the valvular lesions unless associated with degenerative changes in the aorta in later life. It is not progressive in the same degree as mitral stenosis, presumably because the unyielding wall of the aorta to which the valves are attached maintains its contour, and is not drawn in by the cicatricial contraction which affects the damaged valves. If, however, all three cusps of the

stenosis result. Aortic Stenosis and Incompetence Combined.—I think that there can be no question that when a moderate degree of stenosis supervenes on severe aortic incompetence the result is beneficial in so far as it diminishes the amount of reflux, and in more than one case of severe aortic incompetence I have seen this exemplified. The combined lesion, however, though limiting the amount of reflux, puts increased work on the left ventricle, and in some cases the stenosis progresses to such an unfavourable degree, as the result of cicatricial contraction of adherent cusps, that it becomes more serious than the original incompetence.

valve have been attacked by endocarditis, their edges may become adherent and an extreme degree of

MITRAL STENOSIS. The prognosis in this affection is always serious as regards duration of life, though the patient may survive a considerable number of years, as the tendency is for the constriction of the mitral orifice to be progressive. This is due in part to cicatricial contraction, but we must also recollect that in many cases the lesion is established early in life, before the growth of the heart is completed, and thus the relative disproportion between the mitral orifice and the cavities of the heart will increase as the heart attains its full development.

Another unfavourable element in prognosis is the high pressure in the pulmonary circulation. The main work of compensation falls on the right ventricle which hypertrophies in response to the demand. We have thus a powerful pump at one extremity with a narrow nozzle, the mitral orifice, at the distal end of a series of the consisting of the subgroup recode in which of tubes consisting of the pulmonary vessels, in which the pressure must necessarily be very greatly raised. As a consequence the unsupported capillaries become distended and tortuous, project into the alveoli, and frequently rupture. Proliferative changes take place in the alveolar walls, which become thickened, and tend to shrink and contract, and eventually we have the tough, firm condition of lung known as brown induration. The surface available for aeration of the blood is thus seriously impaired and diminished, which accounts for the dyspnoss and cyanosis which are such prominent features in advanced cases.

In attempting to arrive at a trustworthy prognosis in mitral stenosis we cannot rely to the same extent as in aortic disease on the structural changes in the heart as indicative of the severity of the lesion. The degree of hypertrophy of the right ventricle will afford useful information as to the extra work it is called on to do in the way of compensation, but the condition of the left ventricle is very variable. The tendency in simple mitral stenosis would be for the left ventricle to gradually diminish in size as the orifice narrows and the supply of blood becomes more limited, and in many cases post-mortem we find a very small left ventricle with a large hypertrophied right ventricle. often, however, the left ventricle is somewhat dilated and hypertrophied in spite of a marked degree of narrowing of the mitral orifice. The explanation of this would seem to be that considerable dilatation, due to myocarditis, together with mitral incompetence, was the primary lesion following on the attack of rheumatism; that some hypertrophy subsequently took place, and stenosis set in at a later period.

The size of the radial artery and pulse at the wrist affords important evidence as to the degree of stenosis, as it narrows down in proportion to the diminution in the supply of blood from the imperfectly filled left ventricle. Auscultatory evidence affords useful information as to the progress of the affection, as was first pointed out by my late father, who differentiated three stages thereby.

(1) The first stage, in which a presystolic murmur is heard leading up to a loud, short, first sound, followed by a second sound, which is frequently redupli-

(2) A second stage, in which the second sound is no longer heard at the apex, but only a presystolic murmur and first sound.

(3) A third stage, in which the presystolic murmur is lost, and only the first sound is audible.

In the first stage the symptoms are rarely of a serious nature. There may be some cyanosis, and dyspnæa may be readily induced if the stenosis is of old standing, in consequence of secondary changes in the lungs already referred to, but as a rule the symptoms are not severe enough to compel the patient to lie up unless bronchitis or some other complication supervenes. It will be noted on careful observation that the duration of systole is considerably shortened, the loud, snapping, first sound being rapidly followed by the reduplicated second, and that diastole is prolonged. This is only what we should expect, as it take a longer time than normal for the blood to flow from the auricle through the narrowed orifice to the ventricle, and it is probable that when systole com-mences the ventricle is imperfectly filled, and the systolic period will be shorter and less forcible in proportion to the diminished amount of work the ventricle has to perform.

In the second stage, I think we are justified in inferring that the second sound is no longer audible at the apex, because the diminished volume of blood pro-

pelled into the aorta at each systole is too small to pened into the aorta at each systole is too small to distend the aorta sufficiently to produce the powerful recoil which is necessary for the generation of an audible second sound. Consequently, if we accept this explanation, we may infer that the degree of stenosis is considerable, inasmuch as the ventricle is second to the proposition of the consequence of the consequen so imperfectly filled, and that the prognosis is proportionately more unfavourable.

In the third stage the disappearance of the pre-systolic murmur indicates the breakdown of compen-sation. The rhythm is extremely irregular, and frequently we hear a confusing medley of sounds on listening at the apex—sometimes a first sound, sometimes a systolic murmur, sometimes both. The explanation appears to be that the right ventricle having given out, there is insufficient pressure in the left auricle to generate a presystolic murmur; this accounts for its disappearance. When the pressure in the auricle is sufficient to prevent reflux from the ventricle we have a first sound only; when the pressure in the auricle is so low that it does not prevent reflux we have a systolic mumur. The pressure in the left auricle varying greatly according to the force and frequency of the beats of the right ventricle, and being also influenced by respiration, we thus have this confusing medley of sounds. We are apt to forget that in mitral stenosis there are frequently no valves, but simply a slit, or circular hole, in a diaphragm of fibrous tissue between the auricle and ventricle, and that in all cases we should have mitral reflux were it not prevented by the high pressure in the auricle maintained by the hypertrophied right ventricle. The occurrence, therefore, of mitral reflux when the right ventricle breaks down, in cases where it has not been present for many years, is readily understandable. Of course, apart from this, mitral incompetence is very frequently met with combined stenosis, and I am inclined to think that this combination is more favourable than stenosis alone as indicating that the orifice is not greatly contracted. the auricle and ventricle, and that in all cases we indicating that the orifice is not greatly contracted, and that it may in some instances represent an earlier stage of what eventually develops into pure mitral stenosis when the orifice becomes too small to allow of regurgitation.

The symptoms are, perhaps, some of the most important factors in prognosis. Cyanosis and dyspnosa on slight exertion are especially liable to be present, and the degree of ease with which they are induced effords useful evidence as to the baneful effect the high pressure in the pulmonary circulation is having

Infarction of the lungs is frequently met with in the terminal stages of mitral stenosis, and is of grave prognostic significance, as it indicates extreme stasis of the pulmonary circulation. In my opinion it is due to thrombosis from stagnation of the circulation rather than to embolism, and I have never known a case recover efficient compensation after its occurrence. Dropsy of the lower limbs is a very late symptom, and may be absent throughout, though symptom, and may be absent throughout, though ascites is not infrequently met with, whereas in mitral incompetence dropsy is common, and may occur comparatively early in the course of the disease, and efficient compensation may be restored even after the course of the disease, and efficient compensation may be restored even after the course of the co several attacks. In pure mitral stenosis, if present at all, it is usually a terminal feature occurring only in the third stage.

MITRAL INCOMPETENCE.

The range of possibilities as regards prognosis is greater in mitral incompetence than in any other valvular affection. It may be due to a variety of causes, such as dilatation of the left ventricle without any lesion of the valves, as may occur after various acute febrile infections, more especially when the patient returns to work too soon after illness. I have frequently met with it in out-patients recovering from influenza or suffering from acute pulmonary tuber-culosis. It is often present in anæmia, and is met with in Bright's disease, more especially the sub-acute varieties attended with cedema. I do not propose to varieties attended with cedema. I do not propose to discuss the prognosis of these varieties, as it does not fall within the scope of my paper, but I only instance them so that we shall not forget that mitral incompetence may be present without any lesion of the valves, and to support my contention that the latter is not per se necessarily at all a serious affection.

When, as a sequela to an attack of rheumatism in a child, we find the left ventricle greatly enlarged, with a considerable degree of dilatation and slight hypertrophy, and note that there are marked symptoms, such as rapid respiration, dyspnæa on slight exertion, and that a loud blowing systolic murmur is present at the apex, we are, perhaps, too inclined to attribute these to a lesion of the mitral valves. In many cases of this nature, in which enlargement of the liver, dropsy, etc., have set in, and which have eventually proved fatal, I have found at the autopsy no actual lesion of the mitral valves, but only extreme dilatation of the ventricle. This condition is more commonly met with in cases of pericarditis, but may be present also in the absence of this complication. There can be no question here that the fatal issue is the result, not of the valvular lesion, but of the damage to the myocardium inflicted by the toxins of the rheumatic micro-organisms and consequent loss of tone of the muscle, which gives rise to extreme dilatation of the ventricle. Microscopically we see evidence of this damage in the loss of striation, and the granular and fatty degeneration of the muscle fibres, and the areas of cell infiltration scattered throughout. When, therefore, we have mitral incompetence associated with great dilatation of the left ventricle, which does not subside after the attack of rheumatism, the prognosis is necessarily grave. The mere existence of mitral incompetence counct well give rise to dilatation of the left ventricle, but in cases in which compensatory changes in the right ventricle have taken place, we may find the aper beat displaced outwards and slightly downwards by the hypertrophy of the right ventricle.

If a mitral systolic murmur be established during an attack of rheumatism, and there is no marked dilatation of the left ventricle, we may infer that the incompetence is the result of a lesion to the valves by endocarditis, and not attributable to the myocarditis, and we must endeavour to estimate its severity in order to arrive at a trustworthy prognosis. degree to which the murmur replaces the first sound, the character of the pulse, and the readiness with which symptoms are induced, will be our best guide as to the extent of the lesion, and consequently as to prognosis. If a good first sound is audible as well as the murmur, the lesion is rarely so severe as to produce symptoms in the nature of back working, and it is probable that efficient compensation will be readily established under favourable circumstances. It is remarkable in out-patient work what a number of cases of mitral incompetence one comes across in patients who are not aware that they have any cardiac lesion, as compensation is so efficient, and in whom the lesion appears to date from an attack of rheumatism many years ago, if, indeed, they are aware that they have had rheumatism; for in childhood the articular manifestations are often so slight that the patient is not compelled to lay up, and the presence of a cardiac lesion is not even suspected. If the systolic murmur replaces entirely, or greatly modifies the first sound, we may infer that the lesion is severe, inasmuch as the intraventricular pressure is so reduced by the regurgitation through the mitral orifice that it is insufficient to make the muscular wall of the ventricle, as it suddenly contracts down, taut enough to generate a first sound. Consequently, we shall not expect efficient compensation, and slight exertion will be liable to produce symptoms.

One of the dangers to be apprehended in the future in cases of mitral incompetence, which should make our prognosis guarded even in apparently favourable cases, is the possibility of the onset of mitral stenosis, and my impression is that in many cases the patient who has had mitral incompetence for some years, it may be, only comes up for medical advice when mitral stenosis has set in, and symptoms attributable

to that affection compel his attention.

COUNCIL schools at Needham Market have been closed because of an outbreak of diphtheria, and the British schools at Bishops Stortford because of an epidemic of measles. Nearly 200 cases of measles have occurred in the Ilford elementary schools.

# **OUT-PATIENT'S ROOM.**

GUY'S HOSPITAL.

Demonstration upon a Swelling in the Loin, By R. P. ROWLANDS, M.S., F.R.C.S.

This man, who is only 25 years of age, seems to be healthy except for the prominent swelling which you see on the right side of the loin posteriorly. This has been growing for about three or four months, and has rapidly increased in size during the last week. It has caused a little aching pain on the right side of the back, but the patient has been able to do his daily work up to the present time.

There is no history of pneumonia, pleurisy, or any

Inere is no history of pneumonia, pleurisy, or any symptoms suggestive of disease of the right kidney. There is no evidence of phthisis. You will notice that the swelling is strictly limited to the right side of the back in the lumbar region. It is as large as half a cocoanut, and the greater part of it is situated over the space between the last rib, the outer border of the erector spinæ and the crest of ilium. Its surface is smooth and its outline nearly hamispherical thus smooth, and its outline nearly hemispherical, thus suggesting a collection of fluid or a lipoma. The skin is a little inflamed and adherent partly as a result of counter-irritation; it does not crinkle over the swelling. Fluctuation can be easily made out from above down as well as from side to side. Thus lipoma is excluded. Remember that false fluctuation can be excluded. obtained in a lipoma, and also from side to side of the erector spinæ.

The swelling is dull on percussion, and therefore does not contain gas. Although prominent and superficial, it is not translucent, therefore it does not contain clear liquid. There is no history of an injury, and the onset has been gradual, therefore it is not a

hæmatoma.

The gradual onset and the absence of pyrexia and the local signs of acute inflammation exclude acute abscess. The swelling is, therefore, a chronic abscess.

The swelling is, therefore, a chronic assess. It remains to prove its probable origin.

This is not likely to be spinal caries, for the following reasons:—The mobility of the lumbo-dorsal spine is not impaired; pressure upon the spinous processes and upon the head and shoulders fails to elicit any sign of tenderness. Moreover, fluctuation cannot be obtained through the loin from below the costal margin in front or from the region of the psoas or iliacus muscles. The absence of fluctuation upon binancel examination also serves to exclude all varieties. manual examination also serves to exclude all varieties of perinephritic abscess. Moreover, the absence of pyuria, renal pain, and frequency of micturition help to exclude renal disease. I have known a subacute subphrenic abscess of pneumococcal origin give rise to some difficulty in diagnosis. The patient before you is by no means ill enough to suggest a subphrenic abscess. Moreover, there is usually fluctuation upon bimanual examination through the loin when the

abscess is large enough to project below the ribs.

If you look carefully you will notice a small, deep, upward prolongation of the flaccid swelling, and that you can distend this recess by pressing upon the main abscess. You will also notice that there is an impulse on coughing, and that the fluid from the recess can be reduced into the chest through the eleventh intercostal space. It is, therefore, more than probable that the abscess started within the chest, above the diaphragm and below the pleural reflexion. You notice that there is a little dulness at the extreme lower end of the right side of the chest posteriorly; but the air entry good, and there are no indications of empyema in the history or in the physical signs. The old abscess is, therefore, almost certainly due to caries on the inner aspect of the 11th or 12th rib. No thickening of either of these can be made out, but they are tender on pressure. You may remember that tuberculous caries very frequently starts upon the deep surface of the ribs, and that it may affect this surface only. In the "Guy's Hospital Reports for 1907" I drew special attention to this fact, and published drawings of ribs which I had removed, and which illustrated this important fact. The patient from whom one of these specimens

had been removed had had an intermittent discharge over the liver for 20 years, in spite of many scraping operations, and had been supposed at last to be suffering from subdiaphragmatic abscess. For successful treatment it is necessary to explore thoroughly and to remove all that part of the rib which is found to be diseased. Nothing less than this affords permanent diseased. This patient is coming into the hospital for such a radical operation. It is well to remember, however, that, as in most examples of surgical tuberculosis, which are apparently local, there is almost certainly a hidden infecting focus, perhaps in the form of chronic phthisis, or tuberculous mesenteric, or mediastinal glands. When this significant fact is borne in mind, it makes us especially careful of the prognosis in these cases of caries of the ribs in which the infection is from the contiguous pleura in many cases. For this reason, also, after-treatment by injections of tuberculin may be wise.

# OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

FIBROMYOMA OF THE APPENDIX.—REMARKS ABOUT THE METHOD OF REMOVING THE APPENDIX.—MR. CORNER said that the patient was a young man, æt. 23, who had had two attacks of appendicitis, and was sent by his doctor to have his appendix removed. The details of his first attack were meagre, and he was only incapacitated for a few days. In order to understand what is happening in a case of appendicitis, Mr. Corner pointed out, it is important to find some relation between the clinical history, which can be ascertained, and the condition of the appendix, which can only be discovered at operation or autopsy. But the surgeon must try to learn from the clinical history what is going on inside, so as to advise the patient. This case offers a good opportunity to try and find some such relationship, because the patient has a peculiar and striking clinical history. Whilst patient. has a peculiar and striking clinical history. walking down the street in his usual health, he was suddenly seized with abdominal pain, which was so severe as to make him fall down, and necessitate his severe as to make him fall down, and necessitate his removal in a cab. After this he was in bed for seven weeks, during the first three of which he had great abdominal pain. There was little fever, and no sickness. Such a history is so unusual in appendicitis that it would seem that there must be some unusual condition present to explain why it occurred.

In commenting on the operation, Mr. Corner said that it is begun by incising the skin and fat over the right rectus muscle for three or four inches, parallel with its fibres, and half an inch internal to the semi-lunar line. The anterior sheath of the rectus is exposed and incised the length of the wound. exposed and incised the length of the wound. Iwo pairs of artery forceps are placed on the outer lip of the incision in the rectus sheath, which is freed until the outer margin is reached. If a tendinous intersection is present in the rectus muscle, the knife will be the property of the control of the con be required to do this, and at least one vessel will bleed from the cut intersection. The rectus muscle is now withdrawn inwards with two retractors, one in the upper and one in the lower part of the wound, thus exposing the posterior rectus sheath. The nerves to the rectus will be seen running obliquely across the posterior rectus sheath in such a way that they must be divided if a longitudinal incision is made in it. In consequence, an oblique incision, parallel with the nerves, is made through the posterior rectus sheath and peritoneum. The forefinger is now introduced into the abdomen. The most frequent mistake at this stage of the operation is to put the finger straight into the abdomen when it enters the pelvis amongst the small intestines. The proper way to find the cæcum is to feel the brim of the pelvis, and then pass the finger outwards across the iliac fossa, when pass the finger outwards across the iliac fossa, when it must encounter the cæcum where it is attached to the posterior abdominal wall. The cæcum is hooked by the finger and delivered on to the surface of the abdomen. The anterior longitudinal band is followed downwards to the root of the appendix. If adhesions are felt round the appendix, it is advisable to insets some gauze plugs around, as some pus may be enclosed in the adhesions. After delivering the appendix, which in the present case had a number of adhesions, it is clamped, close to the cæcum, with an appendix clamp. The mesentery of the appendix is now secured with two artery forceps and ligature. Whilst this is being done the heavy clamp on the appendix has crushed and divided the mucous membrane and muscular layers, leaving only the peritoneal coats to be tigatured when the clamp is removed. In this way sepsis is avoided in removing the appendix, as it is ligatured with silk at the proximal part of the crushed area, seized with artery forceps just above it to prevent anything within the appendix running out as it is divided at the upper margin of the crushed area. By this method the drop of pure carbolic to sterilise the stump can be dispensed with. The wound is then closed in layers. After sewing the incision in the posterior rectus sheath and the peritoneum, the retracted rectus muscle is allowed to slip back into its proper position and cover the line of sutures. When this is all that has been done to repair the abdominal wall, he had several times seen patients strain or vomit in the course of the operation, and there has been no vestige of a hernial protrusion, showing the very great value of this method for preventing post-operative herniæ. The anterior rectus sheath is then sutured over the muscle, and the skin wound closed.

After the operation Mr. Corner examined the ablated

After the operation Mr. Corner examined the ablated appendix, and found in its distal end a small, rounded submucous tumour, which, having a definite capsule, was of the non-malignant variety. Such innocent tumours of the appendix, he said, were very rare, and practically only fibromyomata had been described. These were found most frequently in connection with uterine fibroids. The presence of this small tumour, he thought, suggested a possible explanation for the fact that the attack began so suddenly as to make the man fall down in the street. Such acute attacks are generally sudden strangulations, perforations, or colic. This patient had no strangulation or perforation. But if the little tumour became intussuscepted into the appendix, he would have very sharp and sudden pain. The length of his illness is also explained by the spontaneous reduction of this little intussusception. Hence this patient may have presented a combination of two unusual conditions—a simple tumour of the appendix and an intussusception of the appendix.

Microscopically, the tumour was a fibromyoma.

# TRANSACTIONS OF SOCIETIES.

THE ROYAL SOCIETY OF MEDICINE.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

MEETING HELD THURSDAY, MARCH 12TH, 1909.

The President, Dr. HERBERT R. SPENCER, in the Chair.

Dr. Drummond Maxwell read the clinical account of a

The case occurred in a primigravida, æt. 26. The chief features of interest in the case lay in the difficulty of diagnosis, since the patient, after admission to hospital, ceased vomiting, and there was only the history of severe vomiting at home, unassociated, however, with marked wasting. The toxic nature of the case did not reveal itself in any characteristic alteration of the urine; there was no albuminuria; the only ominous signs on admission were drowsiness and a very rapid, weak pulse; there was no jaundice. Patient passed successively through stages of restlessness, delirium, mania, and final coma. Autopsy revealed hyaline degeneration and necrosis of the central cells of the hepatic lobules, the kidneys also showing a severe parenchymatous nephritis; sections of both tissues were shown under the microscope. The diagnosis of this distinctly atypical case was uncertain during life, and was based finally on the pathological investigation pest-mortem.

A short communication was read on a case of PRIMARY OVARIAN ACTINOMYCOSIS,

by Dr. Frank E. Taylor and Welby E. Fisher, F.R.C.S. The authors pointed out that actinomycosis of the ovary constitutes one of the curiosities of gynæcology, only six cases of this condition being on record. In none of these had the ovary been the primary seat of infection, but had been infected by extension of the disease originating either in the intestines or in the vagina, uterus, or Fallopian tubes.

The authors claim that in their case the ovary was the primary seat of the disease. The patient was a cook, æt. 34, and single, and was admitted into the Chelsea Hospital for Women in June, 1908, complaining of abdominal pain. The periods were very irregular, and very profuse. Pain was first noticed 3½ years before, and soon after she became troubled with night sweats, which had continued up to admission. About this time she was seen by Dr. Fenton, who found the right ovary enlarged. The patient declined operation at this time. Pain and discomfort continued intermittently, and at one time she passed blood and pus in the urine. Marked anæmia and loss of flesh finally led the patient to enter the hospital. She was then found to have a tumour the size of a child's head, which filled the pelvis. There was no tenderness, but the tumour was fixed. The temperature was raised. The tumour was removed, when it was found to be very adherent to the surrounding parts. Both Fallopian tubes were occluded, and bilateral salpingo-cophorectomy was performed. The patient for a time was very ill, but she ultimately recovered, and left the hospital with a small sinus. Shortly after a large abscess burst, and a large amount of pus escaped through the sinus. The patient at the present time is fairly well, with hardly any discharge. The microscopical examination showed masses of streptothrix.

Professor R. F. C. LEITH said that the specimen shown was a good example of ovarian actinomycosis, caused by the streptothrix actinomyces, but caution must be exercised before accepting the contention of the authors that the disease was primary in the ovary. Of the recorded cases of actinomycosis involving the ovary, a not inconsiderable number, there were some in which the evidence favouring a primary incidence of the disease in the ovary was very strong, sufficiently so to convince their observers of their authenticity. In the case under consideration, the clinical history, both before and since the operation, lent considerable support to the authors' contentions, but the actual relationships of the ovary to all the neighbouring tissues were not fully revealed. Professor Leith referred to a case investigated by him in which the ovary and part of the tube were affected. The rectal was thickened, and in the dense fibrous adhesions binding it to the ovary there were plentiful actinomyces growth. Colonies were also found in the rectal myces growth. Colonies were also found in the recusion wall and in the wall of the descending colon. His interpretation of this case, though still sub judice, placed the primary disease in the intestine, from which it had spread to the ovary, the intestinal lesions subsequently cicatrising and healing. He ventured to suggest that a similar interpretation might be placed upon the present case. The speculation of the authors that the actinomyces had entered the body by some hidden path without causing a local lesion, and had been carried to the ovary by the blood stream, was scarcely probable. One of the chief characteristics of this disease was the formation of a local lesion at or near the site of entrance, and a spread therefrom by direct continuity of tissue. Spread by the blood stream did take place, particularly the portal blood stream, but this was characteristically a late method

Dr. W. S. A. GRIFFITH referred to a case of actinomycosis affecting the generative organs in a women which had occurred in his practice. The nature of the disease was not suspected until late in the illness. The patient died from exhaustion.

of extension.

Dr. T. G. WILSON remarked how difficult it was to be quite sure that a condition like actinomycosis was really primary in the ovary, but had not come originally from some part of the bowel. Illustrating

this point, he mentioned a case of actinomycosis he had seen, when the vermiform appendix was adherent to a right-sided ovarian mass containing pultaceous material, and that subsequently to operation the presence of actinomycosis was demonstrated in both the appendix and in the ovarian mass. In this case the opinion was arrived at that the condition was certainly a primary infection of the bowel, which had spread to the ovary via the adherent appendix.

Dr. Hy. Russell Andrews read notes of a case of PRIMARY CARCINOMA OF THE VAGINA, in which the uterus and the whole of the vagina were removed. The patient, a multipara, æt. 62, had a carcinomatous ulcer, the size of a two-shilling-piece, high up on the posterior vaginal wall. The cervix was free from carcinoma. The whole vagina was dissected out from below, and removed together with the uterus. At an early stage of the operation the vagina uterus. At an early stage of the operation the vagina was converted into a closed bag by clamping with forceps bent at a right angle, with the object of preventing infection of the raw surfaces by carcinoma cells. The peritoneal cavity was closed by sutures, and the cavity between the rectum and urethra became obliterated. The patient was quite well when last seen, February, 1909, eighteen months after the operation. operation.

The President had operated by Wertheim's method on a case of primary cancer of the vagina, and although the patient recovered, she died within about a year of recurrence. He thought there was some advantage in the operation performed by Dr. Andrews, especially as there would appear to be less risk of the vagina tearing: this was very liable to occur in primary cancer of the vagina owing to the thinness and friability, and occurred in his case. He had seen at least three other cases of cancer of the vagina, which these cases appeared to be very great, but Wertheim had had some cases of prolonged freedom from recurrence after the extended abdominal operation.

Dr. F. J. McCann said he had operated on a

patient with primary cancer of the vagina by a method which had not been mentioned by the author of the paper. A wide transverse incision was made through the anterior vaginal wall. The bladder and ureters were separated and the utero-vesical pouch opened. The were separated and the utero-vesical pouch opened. The fundus and body of the uterus were rolled out by slow, gentle traction with volsellum. The broad ligaments were ligatured from above downwards. The posterior vaginal wall was next divided on either side, and the uterus and posterior vaginal wall pulled further outwards. The posterior vaginal was then divided transversely well below the growth from the peritoneal aspect, and was removed along with the uterus in one piece. This patient was free from recurrence when less seen at years after the operation. Dr. McCann last seen 44 years after the operation. Dr. McCann had seen five examples of primary cancer of the Dr. McCann vagina.

Dr. H. MACNAUGHTON-JONES referred to a case of primary carcinoma of the vagina which he had brought before the British Gynæcological Society in May, 1907. Seeing the very few cases of primary car-cinoma of the vagina recorded in British literature, he had sought for some statistics from abroad. From all these sources he had only been able to collect 23 instances of primary disease. The interesting point in his—Dr. Macnaughton-Jones'—case was that it in his—Dr. Macnaughton-Jones'—case was that it exemplified the two types of disease as described by Roger Williams—the tubular, or more chronic form, with actively proliferating columnar epithelium, and the nodular or squamous type, occurring in nests, in which the dissemination occurred more widely and spread more rapidly. George Noble, of Atlanta, had referred to the frequency with which primary carcinoma originated in the region of the urethra, as well as in the posterior wall. All authorities were agreed as to the disheartening results of operation, even the most radical measures being usually unsuccessful in preventing recurrence. In deciding the point of primary infection, it was absolutely necessary to exclude the portio and vulva.

Dr. A. H. N. Lewers said he was surprised to find

some of those present considered this condition very rare. He had himself seen, speaking from memory, at least fifteen or twenty cases of primary carcinoma

of the vagina. In none of them, however, was the disease at a sufficiently early stage to induce him to attempt a radical operation, and he had therefore been obliged merely to scrape and cauterise the growth in such as had seemed to require some active treatment.

Dr. RUSSELL ANDREWS, in reply, said that this was the only case of primary carcinoma of the vagina that he had seen. From what he had read he had considered that the condition was rare. He was surprised that some of the speakers considered that primary carcinoma of the vagina was fairly common. Dr. Macnaughton-Jones had shown that it was rarely seen on the Continent.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, MARCH 12TH, 1909.

The President, Dr. A. R. Parsons, in the Chair.

#### BRONCHIECTASIS.

Dr. JAMES LITTLE exhibited a specimen of bronchiectasis from a man, æt. 25, a car driver, who thought he had caught cold when driving a party to the International football match. He remained at home a fortnight, and then became so ill that he was brought to hospital. He was extremely short of breath and Later he became breathless to the last degree, and had the peculiar hue which Dr. Hudson used tosay was a fatal hue in heart disease—a mixture of unaerated blood and jaundice. He lived three days afterwards. His temperature was never elevated, and his pulse was always feeble. Six years previously, when in hospital with scarlatina, it had been noticed that his heart was beating considerably to the right. When he examined him he found the sounds over the back of the right chest were those of large cavities in the lungs. Over the lower lobe of the left lung there was dulness on percussion. At the post-mortem the heart was found dragged to the right side by pleural adhesions. Pneumococci were found in the pleural adhesions. Pneumococci were found in the sputum during life. The lower lobe of the left lung was extremely congested, and the cause of death appeared to be pneumonia. The right lung presented immensely dilated bronchial tubes in every part. The auriculo-ventricular orifices of the heart were much dilated. The left ventricle was considerably dilated and hypertrophied. The right ventricle was extremely dilated and somewhat hypertrophied. The patient brought up a large quantity of purulent spit, but it was not offensive in smell, which was very strange, as he could hardly conceive a lung less able to expel sputum before it decomposed.

Sir John Moore said that if the bronchial tubes were dilated throughout the entire length there was less likelihood for putrefaction and consequent foctor to occur than if dilated through only a portion of their extent. The condition of the left base looked like collateral hyperæmia rather than pneumonia, as the

temperature was not high.

CEREBRAL TUMOUR. Dr. Coleman exhibited a brain tumour from a girl, æt. 25. For about six months previous to her admission to hospital last month she had suffered from persistent headache, and for the last three or four from occasional vomiting. On examination she had paralysis of the right external rectus, and double optic neuritis. To relieve the headache and pressure he performed lumbar puncture, and removed, under considerable pressure, 19 cc. of practically normal fluid. She died a week afterwards of gradually progressing dulness passing into coma. At the postmortem a large tumour was found involving the right frontal lobe of the brain. It was distinctly circumscribed, and could easily shell out of the brain substance. Microscopically it was a sarcoma. There were no localising symptoms.

The PRESIDENT recalled a similar case in which there was no paralysis, but a marked alteration in the mental condition of the patient. Before he died he developed paralysis on one side of his body.

Mr. Wheeler said the specimen was encouraging to the surgeon, as there was no doubt the tumour could be successfully removed if it could be diagnosed.

POLYSEROSITIS.

Mr. W. I. DE C. WHEELER exhibited organs from a Mr. W. I. DE C. WHEELER exhibited organs from a case of polyserositis. The patient, a man, æt. 34, had been sent from Galway, with a large ascites. He was fairly healthy and had no other symptoms. Two years previously he had had his right pleura tapped, and when he came to hospital a small left pleural effusion was found and tapped. The ascites increased in hospital. Ten days after admission the abdomen was opened. Covering the liver there was a thick capsule, and over it there were little dips as if peas had been pressed into the surface of it. The liver was not cirrhosed. There were adhesions between the great omentum and the abdominal wall. The Talma-Morrison operation was performed. No signs of tubercle were found, and there was no growth of any kind. The operation seemed to relieve the ascites, and he lived eight weeks. He was only tapped once after it, and a very small quantity of fluid was

Dr. HARVEY said that on opening the abdomen only a small quantity of fluid was seen, but a considerable amount was afterwards found shut off by intestinal adhesions. The peritoneum covering the intestines was everywhere thickened, and in places an abundance of comparatively recent fibrin was matting the coils together. The liver was covered with a thick, opaque white capsule, in which irregular pits were seen, giving somewhat the appearance presented by snow on which drops of water is sprinkled. The surface of the spleen was somewhat similar. The cut surface of these organs was scarcely, if at all, abnormal. The spleen was perhaps a little tough, but not at all markedly cirrbotic. The kidneys were normal in macroscopic appearance; their capsules stripped easily. The thoracic viscera were densely adherent to themselves and to the parietes. It was found possible after some time to isolate the left lung which, in addition to general adhesions, was firmly attached to the diaphragm by a dense finger-like process. The pleura was enormously thickened, and the whole organ when removed looked rather like an enlarged spleen. It was not possible to separate the heart and peri-cardium from the right lung. The pleura was not so extremely dense as that on the left side, and the right pleural cavity contained a considerable amount of fluid. The pericardium was greatly thickened and closely adherent everywhere to the heart. On section it had a dense cartilaginous appearance. The heart it had a dense cartilaginous appearance. was somewhat atrophic, the endocardium normal. In-oculations were made from the centrifuged fluid in the pleural and peritoneal sacs into four guinea pigs, but without result. Microscopic sections show the organs to be remarkably free from cirrhosis except immediately beneath the thickened capsules. These latter are formed of a dense connective tissue which has undergone hyaline change. The organs themselves are fairly normal, but for congestion and some parenchymatous degeneration to be seen in the liver and kidneys. Part of the left lung near the pleural surface shows collapse with fibrosis, while portions of the right lung are emphysematous. To sum up, the organs, with the exception of the above-mentioned changes, were healthy, while their serous coverings were im-mensely thickened, and such serous cavities of the body as were not totally obliterated were distended with fluid. There was absolutely no evidence of tuber-culosis either in the sections or as a result of inocu-

Dr. KILPATRICK said he had seen the patient during life, and was very much of the opinion that the multiple serous effusions were probably the result of tubercular infection. He saw him after the operation, and he was perfectly comfortable and better. Then he suddenly died. Both the pathological finding and the clinical history were very remarkable.

Dr. MOORHEAD said he had seen an almost

identical case two and a balf years ago. Such cases were of very considerable interest from their rarity. Mr. Wheeler, in reply, said it had occurred to him that tertiary syphilis might explain the case, but there was no history of such.

Dr. HARVEY, in reply, said the remarkable thing was not why the man died, but how on earth he lived. He had seen nothing so dense as the mass of adhesions in his thorax, and it was wonderful how the organs could move at all.

ORGANS FROM (a) PHARYNGEAL DIPHTHERIA.

(b) CASR OF HEART DISEASE.

Dr. O'CARROLL exhibited a pharynx from a child who had suddenly died, convalescent from pharyngeal diphtheria. He also exhibited specimens from a woman, æt. 46, who came to hospital apparently in the last æt. 40, who came to mospital apparatus, ... stage of heart disease, with dropsy, and some degree of cyanosis. She sank after about ten days. diagnosis was mitral regurgitation, although there was no distinct murmur.

Dr. EARL said that in the first specimen there was a deep ulcer into the tonsil, and the membrane extended down to the base of the larynx. In the other specimens the heart showed general hypertrophy of all the chambers, with some dilatation. Both mitral and tricuspid orifices were abnormally large. The valves were healthy. The aorta was much dilated and atheromatous. The right kidney contained an enormous infarction. The other kidney was a very small organ, and contained calculi. The capsule was very adherent, and there was practically no cortex. A myoma was found in the uterus, also an ordinary mucous polypus, and another on the wall. The other organs were

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT SHEFFIELD ON MARCH 19TH, 1909.

The President, Dr. J. W. MARTIN (Sheffield), in the Chair.

A vote of condolence to the family of the late Dr. J. H. Keeling, an original member of the Society, was proposed by Dr. LLOYD ROBERTS, seconded by Mr. R. FAVELL, supported by the PRESIDENT, and carried.

Mr. R. FAVELL (Sheffield) showed a specimen of

hydrosalpinx.
Dr. A. J. Wallace (Liverpol) showed a glass vaginal nozzle, which he had removed from the bladder by the vaginal route. The nozzle was 5\frac{3}{2} inches in length and \frac{3}{2} inch in diameter. It had slipped into the bladder, seven weeks previously, during the process of vulval douching, by a nurse, of a recently confined woman.

Mr. ARTHUR CONNELL (Sheffield) described a case, and showed the specimen, of
COMPLETE TORSION OF THE INTERNAL GENITALIA WITH A

LARGE INTERSTITIAL FIBROID.

The patient, a spinster of 50, had suffered, on several occasions during the previous five weeks, from subacute attacks of abdominal pain and vomiting, which had always commenced during defæcation. Her medical attendant had found an abdominal tumour of about the size of a six months' pregnant uterus. The last attack was the most severe, and had lasted three days when Mr. Connell first saw her. She was then desperately ill. He diagnosed a fibroid with torsion of its pedicle, and advised immediate operation. The uterus and its appendages were rapidly removed, after a preliminary enucleation of the large interstitial myoma. The uterine and ovarian vessels were thrombosed and did not require ligaturing. The patient made a good recovery, though a transient hemiplegia commenced on the day after operation. The cavity of the uterus was distended with blood clot, and the uterus with its appendages and the tumour were in a state of infarction. Mr. Connell also showed a portion of the pelvic colon successfully resected on account of its dense adhesion to a pyosalpinx.

Dr. A. CUFF (Sheffield) showed the macroscopical

and microscopical specimens from a case of bilateral, malignant, papillary cysto-adenoma of the overies. There was considerable ascites, and the peritoneum was studded with papillary growths. Three months later there were no signs of recurrence.

Dr. LLOYD ROBERTS (Manchester) read the notes and showed the specimen of a case of carcinoma of the corpus uteri, successfully removed, per vaginam, from

a multipara, æt. 58.
Dr. J. E. Gemmell (Liverpool) read a short paper on

FIBROMYOMA UTERI AS A CAUSE OF PURPPERAL TOXAMIA.

He related three cases which illustrated different
methods of puerperal infection dependent upon such growths: (1) Strangulation of the pedicle leading to sloughing and general septic peritonitis; (2) toxemic from necrosis of the growth itself; (3) sapræmic infection from the placental site together with necrosis of the growth. The first two cases were successfully treated by subtotal hysterectomy. In the third case a sloughing, submucous fibroid was removed piecemeal, per vaginam, on the sixth day of the puerperium. Immediate improvement followed, but death, from pulmonary embolism, occurred a few days later. He advocated, in the absence of symptoms of toxæmia, that the tumour should be left until involution is completed and then dealt with by any operative method which is deemed most suitable, but when toxæmia arises, from any cause whatever, complete or subtotal hysterectomy is the operation of choice and the safest.

# CORRESPONDENCE.

# FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 28th, 1909.
GRIPPE AND ITS TREATMENT.

GRIPPE, or influenza, is one of the commonest affections, returning each winter to afflict humanity; and yet, although so well known, few diseases have given rise to so much difference of opinion and engendered so many opposing theories. Broussais simply denied its existence: for him, grippe was an imaginary affection created by doctors in quest of new patients!

At the Académie de Médecine grippe was the subject of numerous discussions, and the cross-fire of ideas put forward rendered it difficult to form a rational popular.

opinion.

Some years ago influenza was considered a benign affection requiring only a few days' rest by the fire side. Yet four epidemics of the malady were observed in the last century: those of 1830, 1836, 1848, and 1889. The last came from the extreme East. It began at Bokhara in May, attained Moscow in September, St. Petersburg in October; towards the middle of November Berlin was infected, then Paris and London. In one year it encircled the globe.

A malady is at first diagnosed by the symptoms that appeal to our senses. Pathological anatomy can, in certain cases, furnish its contribution to confirm the diagnosis, but in grippe this latter means is wanting.

The cause alone and the discovery of the exciting agent (microbe) could furnish a decisive argument. It was thus that on all sides efforts were made to isolate the microbe. In 1902 Pfeiffer described a bacillus that everyone thought to be specific. It was found in Russia in the waters of the rivers, and it was said that its presence was constant in the expectoration of the patients. But this discovery was found to be inexact, for in 1905 Besançon made a communication before the Hospital Society in which he showed that in 25 patients examined the bacillus of Pfeiffer could not be found.

Kietz and Stemberg made similar observations at Vienna a few weeks later: they found but pneumococci and certain kinds of saprophytes. speaking, influenza increases in gravity in passing successively through organisms as explained by its greater malignity in the present day as compared with the

The influence of our social living, says M. Besançon, made up of mental and physical strain with

cerebral fatigue might be invoked. The more we live, the more the malady seems to localise itself in the nerve centres, as proved by the epidemics of cerebrospinal meningitis following grippe, observed in Germany and in certain regiments in France, and also in some scattered regions.

Grippe may present itself in one of three forms, or

the three forms may coincide: Respiratory grippe; nervous form; gastro-intestinal form.

In pulmonary grippe, says M. Le Cendre, the inva-sion is generally brusque, the cough incessant and wearisome; the larynx is inflamed, and the lungs are rapidly affected; souffles and rales of a special viscous character are observed over the lungs, while nervous phenomena predominate, with paralysis of the vaso-motor system, resulting in intense and persistent vaso-dilatation; the dilated vessels seem paralysed, while the muscles of Reissessen have lost a great part of their elasticity.

In the nervous form, the patients are considerably agitated and complain of lancinating pains in different regions, resembling seizures of neuralgia.

The gastro-intestinal form is characterised by violent and frequent vomiting, with profuse diarrhœa, while

the tongue has a peculiar opaline aspect.

Complications of grippe are as numerous as they are grave. In the first place, grippe is a frequent exciting cause of tuberculosis of the lungs; nephritits is often observed, while inflammation of the liver has been noticed more than once. Meunier observed four cases of septicæmia, and many authors have incriminated grippe as one of the causes of appendicitis. Other affections as peritonitis, otitis, tonsillitis, etc., have been sometimes proved to be in intimate relation with grippe. But one point should not be overlooked, and that is, that an attack of grippe can be followed by a second attack much graver than the first, which had yielded to appropriate treatment. A patient pressed to return to his business, resumes his usual mode of living, and a relapse takes place. Violent mode of living, and a relapse takes place. Violent headache generally accompanies all the forms of grippe with high temperature.

As to the treatment of grippe, it was commonly believed that there was no specific for the disease, but quinine in large doses was good practice. However, according to Dr. Barbary, of Nice, cacodylate of guaiacol is about the nearest thing to a specific. Introduced into the therapeutics of influenza by Dr. Burlyrgany, who found that one or two injections of troduced into the therapeutics of influenza by Dr. Burlureaux, who found that one or two injections of 1 gr. lowered the fever with astonishing rapidity, cacodylate of guaiacol was made the subject of special study by Dr. Barbary, who, after employing it throughout last winter in all the cases of grippe that came under his observation, arrived at the following conclusions:—Cacodylate of guaiacol had the best effects in persons suffering from grippe, it attenuates the infecin persons suffering from grippe, it attenuates the infec-tion, rendering it benign; injections of cacodylate of guaiacol lower the temperature and rapidly improve the condition of the patient; convalescence, which in many cases is very prolonged, is much abridged; lastly, cacodylate of guaiacol prevents complications so frequently observed in patients of advanced years.

The dose is 1 gr. morning and evening in subcu-

taneous injections.

TREATMENT OF CONVULSIONS.

Convulsions in children are very frequent, as every practitioner knows, and always cause grave anxiety to the parents, who expect prompt treatment from the medical attendant.

The first thing to do where the child is over two years old is to order an enema of salt, oil, glycerin, or honey, and provoke vomiting by tickling the uvula or by a vomitive, for generally the eclampsia is due to some gastric or intestinal disturbance, from simple indigestion to dyspepsia, serous summer diarrhea, or, on the contrary, to constipation; worms are exciting agents.

If the attack continues, a few drops of chloroform or ether may be poured on a handkerchief and given to the patient to inhale largely. A simple warm bath is preferable to a mustard bath, which tends to excite the convulsions rather than allay them.

As soon as the child has "come round," it should be put back into its bed, and the treatment renewed if the convulsions return. The seizure should not in any case be considered as ended until the patient has urinated abundantly.

Other methods have been recommended: Compression of the carotids by means of one or two fingers. To avoid dragging on the skin, and consequently compressing the larynx, the skin should be first pinched up and drawn towards the larynx; to avoid compressing the jugular vein, by which cerebral congestion would be increased, it is best to employ but one finger on the artery. Leeches only find their indication in two cases—uræmic convulsions and venous congestion of the brain. Chloral should be given with caution and in fractional doses every 15 or 30 minutes, taking the age of the patient as a guide: infants, 1 to 3 grains; from two to six years, 4 to 6 grains; from ten to twelve, 3 to 10 grains. A chloroform odour of the breath indicates that the drug should be discontinued.

Bromide of potassium or of calcium may be employed alone or associated with chloral.

Berthez and Demme preferred bromide of ammonia to other bromides, its anti-congestion properties being better marked.

Ritten (Berne) advised atropine in hypodermic injections in children over 6 years of age (1/64 to 1/32 gr. per 24 hours).

Valerian is sometimes useful given in enema:-

Valerian root, 1 to 4 dr. Boiling water, 3 oz.

Add:-

Chloral, 2 to 10 gr. Musk, 1 to 4 gr. Yellow of egg, No. 1.

GERMANY. Berlin, March 28th, 1909

AT the Medical Society Hr. Julius Ritter gave an address on

STREPTOCOCCI IN DISEASES OF CHILDREN AND TREATMENT BY ANTITOXINS.

He described the occurrence and importance of streptococci in the most varied diseases, where they were mostly without significance, at least not specific, as in articular rheumatism. They gained a certain known importance in mixed infection with the bacilli of diphtheria. In scarlatina they were by no means so constant; they were sometimes found in very mild cases, whilst they were sometimes absent in the gravest The agglutination test of scarlet fever serum with streptococcus bouillon was always positive, on the other hand, even with extreme dilution. From numerous clinical observations it appeared that the pathogenous activity of streptococci depended in the first instance on the nutrient soil, on the tissues on which they grew. He was strengthened in this view by examinations of the blood of patients suffering from recurrent erysipelas; in these he found the white blood corpuscles reduced to 4,000 or 4,500.

In his investigations he had made use of the Aronsohn and Hoechster serums. He first treated 22 cases of erysipelas in children, where the fever diminished on the second day and entirely disappeared on the third. The doses given were 20 cc.m. of serum to each no kg. of weight. Four phlegmons starting from the umbilicus, all died. Of 19 bad cases of scarlatina 10 recovered, the rest died. Fourteen cases of septic diphtheria were treated with diphtheria and streptococcus serum; 6 recovered, 8 died. After these experiences the speaker considered that treatment with streptococcus serum should be further tested in appropriate cases.

Hr. F. Meyer said that practically the period of time for the injection was of importance, the injection should be made before the symptoms of general sepsis had become pronounced. Lately attempts had been made to use the serum locally in the form of powder.

Hr. Peiser pointed out the great differences there were in children, as regarded the dangers of infection, due to their different conditions as to nourishment, Breast children were distinctly less endangered than bottle children. It was possible that these differences were of importance as regarded the efficiency of serum treatment.
Hr. F. Schlesinger had seen a good effect from serum

treatment in one case of septic scarlatina. Two of a family became ill, apparently both equally so; one child died in three days without any injections, the other visibly improved after injection and recovered.

Hr. Th. Landau had treated 15 cases of puerperal fever with serum; two died. As soon as the diagnosis was certain 100 cc.m. of serum were injected, after which one litre of saline solution was given, and the day after large enemata of the like solution. The temperature had generally fallen to normal in 36 hours, if it rose again 50 cc.m. more serum were given, some-times even a third dose was given. The effect on the pulse was rapid, it only failed to be seen in the two cases that were fatal. How far the saline infusion assisted in the good result was not certain. The calmative effect was remarkable, the sleep that had been long wanting sometimes came on even whilst the injection was going on. He was of opinion that failures occurred when the medicine was given too late, or not in sufficient quantity. The treatment was contraindicated where local lesions were present.

Hr. Liepmann pointed out the great difficulties there were in the way of an exact estimate of the value of the remedy in a disease so varying as to prognosis as puerperal fever. He had given the serum prophylactically in 100 cases; r had died. In the 100 control cases there were no deaths.

Hr. Aronsohn pleaded for State manufacture of the serum. It was still far too dear. too cc. m. cost 40 mark.

# AUSTRIA. Vienna, March 28th, 1909.

DIAGNOSIS OF NASAL DISCHARGES.

CHIARA in his clinical lectures tells us that chronic discharges from the nose are somewhat misleading if not carefully differentiated. For instance, chronic catarrh with a profuse discharge is a rare condition to meet with, and is more likely to be associated with some of the dependent parts of the nasal cavity. Syphilitic ulcers and necrosis are not uncommonly the cause of many of these chronic conditions. The discharges in these cases are usually bilateral, associated with an evil-smelling discharge, a stabbing sensation, with the surroundings chafed and irritated. Close examination may locate the ulcer, which the sound will confirm by the grating on the bone. The periosteum is usually swollen and painful over a wide area, and the history of contagion a decennium previously is sufficient to confirm the diagnosis, without any other symptom of syphilis being present, except this gumma or necrosing ulcer in the cavity. Foreign bodies and rhinoliths are also fruitful

causes of chronic discharges when they have existed for any length of time, but these are usually recognised by being unilateral. The discharge is also offensive, but the sound increases the flow by relieving the obstructions.

In the case of ozena both sides are equally affected with offensive odour and discharge, even when the atrophic process is well advanced, this symptom is prominent.

when one of the neighbouring canals is affected the purulent discharge is also unilateral, the secretion appearing mostly in the erect posture, hence early in the morning after the night's rest. This discharge is usually thin or fluid pus leaving a hard dry crust in its trail. This fluid may or may not have a slight order. odour, but none as a rule.

SYPHILIS AND NURSES.

Pollak called attention to the abuse of those institutions where children are taken in to be nursed on the breast by showing an infant three months old with well marked congenital syphilis. The infant had been taken into the institution eight days after birth. and kept there at the breast of a nurse till a fortnight ago, when it was discovered by accident. Surely, he said, a remedy can be found for this destructive practice. He proposed recommending the Government making this penal, and placing all such institutions under the guidance and direction of a specialist.

STRUMECTOMY AND TETANY. Boese gave the members an exhaustive account of an operation he performed on a female, æt. 20, for a colloidal enlargement of the thyroid and tracheal compression. Ten days ago after tying the two inferior thyroid arteries and removing the two inferior horns of the gland; the posterior capsule and pale parenchymatous sheath with upper horns of the gland were left intact, severe tetanic fits set in about 24 hours after the operation, which continued for two days without intermission, notwithstanding the application of para-thyroid extract and an alkaloid. After two days had passed and the case looking hopeless, it was resolved to transplant a few epithelial bodies taken from the thyroid of another healthy woman and implant in the peritoneal cavity. The heroine who provided the remedy left the hospital a few days after, and is now perfectly well. Immediately after the transplantation the patient began to improve, the tetanic fits receding. On the third day after the implantation the patient expressed herself perfectly well and free from any spasm.

Bence Jones' Albuminuria.

Gerber related the history of a case of albumose which he diagnosed as Bence Jones' albuminuria, from the peculiar behaviour of the urine with acetic acid. The patient was a male, æt. 56, who was found to be diabetic, with 0.6 per cent. of sugar in the urine. When acetic acid and potassa ferro-cyanide were added, a cloudy deposit forming \( \frac{1}{2} \) per cent. was thrown down, but in the albuminometer it was over .12 per cent. The Buiret reaction, with a weak solution of Cu SO<sub>4</sub> and liq. potassæ was tried, and a pronounced red colour was produced. After this the angle of rotation was to the left, indicating the presence of 2.1 per cent. of sugar, although the rotation was to the right at the commencement.

With concentrated acetic and nitric acids the urine assumed a dense cloudy appearance that rapidly became gelatinous. After the failure or negative condition of the alcohol and ammonium sulphate test, he concluded that the patient was suffering from Bence

Jones' albuminuria.

HYPER-IDROSIS MANUUM.

Freund showed a case of liquitive perspiration in the hands, which he successfully cured by means of the Röntgen rays. After six sittings of six minutes, large lamellæ of the epidermis can be seen lifting off the hands. Below these plates the young skin is pale and dry, but at the margins of the radial application, where the rays were not so intensely applied, the parts seemed moist and soft, indicating that the curative effect was not so complete where the radial effect was weak.

HEALTH OF VIENNA FOR JANUARY.

The official report of the two benefit societies of Vienna has just appeared for the month of January, which may interest the sanitary statistician. There are 310,000 members, of whom 280,000 belong to Venna proper, the others to the suburbs. The number laid up from accidents and sickness during the year were 71,464. Of these, pulmonary tuberculosis claimed 1,138, influenza 562, simple pulmonary inflammation 54, while a miscellaneous number of other pulmonary affections embrace 2,018; angina, or throat affections, 592; diseases of the circulation, 371; stomach and bowel, 728; rheumatism, 1,210; and injuries, 1,746. The number of deaths was 319, of which tuberculosis claimed 151, or 47 per cent.! respiratory organs, 34; circulation, 35; neoplasms, 23; injuries, 10; and suicides, 7.

This only represents the industrial or trade societies of Vienna, not the entire population, which is heavily

afflicted with tuberculosis.

# HUNGARY.

Budapest, March 28th, 1909.

At the recent meeting of the Nagyvarad Medical Society, Dr. Schiff read a paper on

ACUTE ARTICULAR RHEUMATISM IN CHILDREN.

He enumerated quite a goodly number of authors who reported cases of rheumatism in the very young, although this disease is comparatively rare in children. It is possible to admit that the disease is transmitted with the milk of the wet nurse. The incubation period in such cases is at least four days, the duration of the disease between two and four weeks; both the duration

and the severity of the disease are less in infants as compared with adults. In the former it may run its course without any complications, while in older children endocardial and pericardial complications, as well as implication of the pleura and nervous system (chorea) are of frequent occurrence. This has been reported by Baudelocque, Rilles, and Bartez, and others. Picot found 50 per cent. of his cases complicated with pericarditis, while Roger asserts positively that every rheumatic child's heart is bound to be attacked sooner or later. The author observed in his case a rather rare complication in the form of an effusion into the maxillary joint.

LOCAL ANÆSTHESIA WITH ADRENALIN COCAINE.

Dr. Konràd said that it has been observed long ago that a part rendered bloodless is much easier narcotised; thus the application of an Esmarch bandage tends to increase the anæsthetic property of cocaine injected into the bandaged part. Adrenalin is known for its decided vaso-constrictor effect, and the lecturer uses a preparation of the drug with cocaine to enforce the effect of the latter in the following mixture: To a 5 per cent, solution of cocaine-hydrochlorate there was added a 1 to 1,000 solution of adrenalin in the proportion of 2 drops to each c.c. of the cocaine solution. The lecturer employed this mixture for local anæsthesia in 42 cases, including such as lipoma of the external genital organs, phlogmon, epithelioma of the right cheek, cancer of the lower lip, chronic ascites of the atheromatous tumours of the forehead, fistula of the lower jaw, and so on. In all of the cases there was induced complete anæsthesia, there was an entire absence of any parenchymatous hæmorrhage, the anæsthetic effect being observed also on the diseased tissues. Dr. Konrad failed to observe any harmful effects of the mixture on the course of healing, nor were there any immediate toxic symptoms, with one exception. Anæsthesia began ten minu es after the injection, and lasted for almost two hours, thus enabling the operator to stitch up the wound pain-lessly. In operating in deep tissues it is preferable to use weaker solutions of cocaine, but in greater quantity. Some authors advise caution in old people and in children. It is a mistake to assume that local anæsthesia may only be employed in so-called minor surgery, for at a recent meeting of Budapest surgeons reports were made of the successful use of local narcosis in such capital operations as hernia, appendicitis, laryngeal growths, etc.

THE ARTIFICIAL INTERRUPTION OF GESTATION BY BOUGIES.

In a recent number of the Orvosi Heti Kemle, a paper is published by Dr. Jakoby on the above subject. The paper is based on a series of 228 hospital cases, and the procedure employed is as follows: The patient is given a cleansing bath and the outer genitals washed with soap and water, but the vagina is not disinfected. The cervix is then seized with one or two bullet forceps, and a bougie (diameter, 8 to 10 mm.), provided with a stylet, is gradually introduced, while guided by the finger and the stylet slowly withdrawn. The bougie may be carried up between the bag of membranes and the uterine wall without any trouble. In 191 cases one bougie was sufficient; in 21 two were necessary; one bougle was sumcient; in 21 two were necessary; in 2, three; and in 1, four. The average time before rupture of the membranes took place was 24 hours, to the completion of labour 31-45 hours. The nearer the end of pregnancy the procedure was instituted the more readily were labour pains elicited. The entire morbidity is stated by Jakoby to have been 6.8 per cent. in the 228 cases. Three cases of fatal issue may be ascribed to the employment of the method, two of these being through sepsis and one peritonitis. In the latter case the bougie failed and Cæsarean section was resorted to. In 114 cases the pregnancy was interrupted for narrow pelvis; in 65 of these labour came or spontaneously; in 49 artificial delivery of these children was found necessary, 65 per cent. lived. As the morbidity rate is not higher than that of institutions in general, the method may be looked upon as quite free from danger and affording a favourable outcome for the child. The simplicity of the method and the frequency with which the labour terminates naturally,

makes it superior to the dilating bags, which practically means the introduction of an accouchement force, or to vaginal section.

332 THE MEDICAL PRESS.

# LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

"DOCTORS AND MIDWIVES."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Nearly half a century of professional life tells me the value of a well-trained nurse, and how invaluable she is to a medical man when he has no other helper. Take a medical man in an out-of-the-way district, who is called to a case needing prompt operation. He has no helper but the nurse, and

cannot wait to send for any help, and, perhaps, if he did send could not get it. Would it not be of service to him, and his patient, if the nurse knew how to give chloroform, and to hand him the instruments needed. to "lock" them, and know she is doing exactly what he wants? Or, there is a bad case of post-partum hæmorrhage, and he is engaged in controlling it by compression of aorta; the patient is moribund, and he turns to the nurse—for he must not relax his hold—and desires her to "give a hypodermic." The medicaments are all there, and he tells her which to use; she knows (having been taught) exactly what to do, and does it to his entire satisfaction. If she knew, neither what to do, nor how to compress aorta, he must leave

his post—and with what result? I do not for one moment wish to supplant the medical man or woman—and I am sure the welltrained nurse will not either-or deprive them of their fees; and I think it a monstrous shame that while the Act was in Parliament, provision was not made refees when medical help is needed by the nurse and her poor patient!

I well know how magnificently generous and nobly self-sacrificing doctors are, and always contended they should be paid; and when I say "the nurse will always be sending for a doctor," I refer to cases of defective practical nurse-training, or where, if she had been trained, and been out of a berth (and, as Dr. Duke humorously puts it, not been at a birth) for some time, and forgotten her once-acquired knowledge, she would be sending for a doctor when there is absolutely no need, and the patient's friends would not, or could not, pay his fee. I have known a kind-hearted doctor often go when a nurse sent, and find no cause (save her ignorance) for sending, and at length decline to go—not because he did not get a fee, but because of his having been sent for without cause as regards mother and child.

Since the sixties I have been training, having experienced the great need for it; in '79 I began to train for work in those places where women only are allowed to attend the women and their children, and gave the pupils all the knowledge, practical experience and skill possible, so that they could act where no help was otherwise to be had, and where, but for their skilled aid, death would claim both mother and child: At home I would have the nurses always call in the doctor—when she, being well trained, knows when he is needed—but I would not have doctors teased by being summoned, simply because the fault lay with the want of knowledge of the nurse.

I do not teach nurses to circumcise, but to be able to know for certain when phimosis exists, and the resulting evils, if not attended to, and inculcate on them their duty—to tell the doctor in attendance.

Vaccination and other subjects I teach, and have for years, for I know the immense value of being able to do it when nurses are away in such places as Africa, China, Burmah, etc., where no doctor is at hand; and I have no cause to regret that such training has been given, especially as those trained did not interfere with any doctor—man or woman—and were benefactors, where otherwise there would have been no help.
I am, Sir, yours truly,

G. DE G. GRIFFITH.

London, March, 1909.

P.S.—Since writing the foregoing, I have come across the following in the Nursing Times of May 30th, 1908:—"Mr. Haldane, Secretary of State for War, gave prizes to the nurses of the Edinburgh Royal Infirmary for materia medica, gynæcology, bacterio-logy, besides those for nursing. In the course of his speech he spoke of 'the great improvement which had speech he spoke of 'the great improvement which nad taken place both in the position and in the training of nurses within recent times.' He said: 'Many people said that there always were nurses in the medical profession, but there was very little in common between the training of a nurse of long ago and that of the present day.' He compared the doctor to the architect who place the building and leaves the carry. architect who plans the building, and leaves the carry-ing out of his instructions to his contractors. The work of the nurses was part of a scientific whole, and their training must have a scientific basis. He told the nurses that their profession should not be regarded from a money-making point of view. It was one in which the keenest interest could be taken for its own sake. Both knowledge and imagination were required in dealing with a sick person, and the greater knowledge they possessed the more they could be helpful. He added it had been a great pleasure to him to be present that day, and congratulated them warmly on the progress their profession was making."

#### MEDICAL INSPECTION OF SCHOOL CHILDREN

To the Editor of THE MEDICAL PRESS AND CIRCULAR. To the Editor of THE MEDICAL PRESS AND CINCULAR.

SIR,—To those of us who, like myself, pride ourselves upon being patriots first and doctors afterwards, the paper by Dr. Carpenter, and your leader upon it this week, afford sorry reading. There cannot be any doubt that, as at present organised, the medical examination of school children throughout the country 18, even from the merely statistical point of view, of very little value, and as no treatment of discovered defects is provided for, it is even of less practical importance. The reports of the medical officers of boroughs in this part of Surrey tell the same tale as that disclosed by Dr. Carpenter. In a neighbouring semi-rural and wealthy "residential" borough of 25,000 inhabitants, only 60 per cent. of parents took the trouble to accompany their shides the trouble to accompany their children on examina-tion day. Several hundreds out of the few thousands at the schools were found with verminous heads; carious teeth with septic mouths were the rule; whilst adenoids and large tonsils, ringworm, and all the small but disabling ailments affecting children were present in great numbers. Children kept from school because they were "not well" wexe found suffering from diphtheria, scarlet fever, and measles. The attempt at elucidating the condition of the children served more than anything to reveal the fact that a vast proportion of the parents were devoid of all knowledge of the management of children, many culpably careless, and many almost criminally neglectful. It must be borne in mind that at this period of the twentieth century in this enlightened England there still exists the necessity for a Society for the Prevention of Cruelty to Children, which justifies its existence by successful prosecution annually in thousands of cases of cruelty. My point is that in Germany they have for many years been taking preventive measures which we are now only beginning to think about. Not only in this, but in every direction of social organisation, the Germans are surpassing us. If this goes on, our Fleet, however predominant, will not save the Empire from ultimate ruin.

I am, Sir, yours truly,
A Provincial Practitioner. Near Reigate, March 25th, 1909.

THE DECLINING BIRTH-RATE To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—From time to time an interesting discussion has taken place in your columns with regard to the import of a declining birth-rate, in which most of your correspondents have held the view that such decline was fatal—or at least detrimental—to the development and maintenance of the British Empire,

and hence to the interests of the English nation. On the other hand, I have on more than one occasion endeavoured to point out and urge that, so far from this being the case, a declining birth-rate in the face of a surplus and unwieldy population was, under all existing conditions (for which I offered reasons) rather a means for congratulation and security than otherwise. Without in any wise affecting to pose as a politician, and with your kind permission, I take the opportunity of referring your late correspondents to the somewhat startling change in the political atmosphere on the recent discussion elsewhere upon the Navy Estimates, which appears, to my fhinking, to give countenance and corroboration to what I have always held, and that is, if we drain our excessive population by means of emigration and the export of our best blood, this procedure must inevitably sooner or later spell national decadence, and hence insecurity of the whole Empire.

Now I think it should be apparent to such correspond to the corresponding to the cor

spondents who have controverted me (at least for the time being) that for the protection of our shores, and for the mere purpose of defence, the population, both from a numerical and hygienic point of view, should so regulate itself that, in the event of conscription or otherwise becoming an absolute necessity, we may insure an army, to say nothing of a navy, capable of coping with any foreign invader. But what I ask is—whence is the army forthcoming if we export our best product to build up an Empire, leaving our own shores as an asylum for the decrepit and destitute, which your correspondents have, as appears to me, hitherto practically insisted upon?

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, March 29th, 1909.

LAW FOR DENTISTS AND LAW FOR DOCTORS. To the Editor of The Medical Press and Circular.

Sir,-On numerous occasions you have allowed me to record in your pages illustrations of the grotesque auomalies in medical law as presented in reports of police court proceedings in the daily papers. The Times of to-day publishes two of such cases, both heard yesterday at the North London Court. In the first instance, an unregistered man had, among other titles, used the qualification, "dentist." He was fined £15 and £3 3s. costs. In the second case a man, also unregistered, had not employed the title "dentist," but had advertised under cover of a "teeth institute." He was fined £10, with £3 3s. costs. If an unregistered medical practitioner assumes a title specifically enumerated in the Medical Acts he may perhaps be fined; but he cannot be touched if he employs bogus titles, or if he practices under cover of a "medical institute," and uses language in his advertisements calculated to lead even educated readers to take him for a qualified practitioner; and he cannot be interfered with if he practises under the cloak of selling nostrums or apparatus, and advertises them under the name of a fictitious doctor, with the effect of making the customers who consult him believe that they are being treated by a qualified man. Not only in dentistry, but, as you have allowed me frequently to point out, in veterinary surgery also, these abuses are not permitted. They continue to exist in the medical profession because the profession remains politically impotent—has no voice, and no means at present of making itself effectually heard even if it had a voice.

I am, Sir, yours truly,
An Obscure Practitioner.

March 16th, 1909.

# **OBITUARY.**

LT.-COL. TUOHY, M.D., M.CH., Q.U.I., M.A., I.M.S. (Ret.).

LIEUT.-COLONEL TUOHY, who died at Brighton, in his 54th year, on February 22nd, was a distinguished officer of the Indian Civil Service, having taken part in the last Afghan Campaign, for which he held the medal. He was stationed for a year at Kandahar

after its occupation. He held the position of Police and Civil Surgeon for 17 years under the Government of the North-West Provinces, and was the first Super-intendent appointed to the Ramsey Hospital Naini Tal, the largest hospital for Europeans in Northern India. Here he held the post of Police and Civil Surgeon, which he also filled at Allahabad, Agra, and Saharapur. At Agra he was Superintendent of the Medical School, and the Colvin and Lady Dufferin Hospital, being a member of the North-West Provinces Committee of the Lady Dufferin Fund. On many occasions he received the official thanks of the Government for the manner in which he performed the duties of Civil Surgeon. Of late years, after his retirement from the service, he followed private practice at Hove, Brighton.

During his service in India he earned for himself a high character for his administrative powers, to which, on several occasions, testimony was given by the heads of the Indian Medical Department. His unexpected death occurred after a comparatively brief illness, and has been greatly regretted by all his old colleagues in the service, and by a wide circle of friends, for he was a man whose personal character endeared him to all who knew him. He was, in the words of one of the chiefs of the Indian Service, "a thorough gentleman, conscientious and tactful in his dealings with others."

SURGEON-MAJOR WILLIAM GALT BLACK,
F.R.C.S.Ed., M.R.C.S.
WE regret to record the death of Surgeon-Major
William Galt Black, a Crimean veteran. He was
born in 1824 at Bolton, where his father, the late Dr.

James Black M.D. who was a Newton Stawart James Black, M.D., who was a Newton Stewart native, was in practice. The deceased gentleman was educated in Manchester and at Edinburgh University. He joined the 11th Foot Regiment, now the Devon-shire Regiment, shortly before the outbreak of the Crimea War, and he served right through that arduous campaign. He was present at the battles of Alma, Inkerman, and Sebastopol, and possessed a number of medals. At the conclusion of the war he served for 10 years in Africa, and he had also other periods to form coving acres to his archibit and the content of the server of of foreign service to his credit in the course of his connection with the Army, from which he resigned 26 years ago. On his retirement he went to reside at 2 George Square, Edinburgh, and devoted his attention to scientific studies. He was a member of the tion to scientific studies. He was a member of the Society of Arts, and in 1883 won the Brisbane prize of that Society for a marine anemometer, which he afterwards exhibited at exhibitions in Liverpool, Manchester, Glasgow, and Edinburgh.

FREDERICK HARCOURT GERVIS, M.D.BRUX., M.R.C.S., L.R.C.P.

WE regret to announce the death Frederick Harcourt Gervis, of the Royal Army Medical Corps, aged 37. Captain Gervis entered St. Thomas's Frederick Harcourt Gervis, of the Royal Army Medical Corps, aged 37. Captain Gervis entered St. Thomas's Hospital as a student in 1891, and obtained a science scholarship as a result of his first year's study. In 1896 he qualified as a member of the Royal College of Surgeons and as a licentiate of the Royal College of Physicians, and two years later he obtained the M.D. degree at Brussels. He was appointed a House Surgeon at St. Thomas's Hospital, and at the Paddington Green Children's Hospital he held, at various times the posts of House Surgeon. House Physician. times, the posts of House Surgeon, House Physician, and Clinical Assistant.

For many years Captain Gervis was closely connected with the Volunteer movement, and was Surgeon - Lieutenant, and subsequently Surgeon-Captain, of the 17th Middlesex Volunteer Rifle Corps.

DR. C. COATES, OF BATH.

DR. CHAS. COATES, who had retired from practice about ten years, died at the age of 83 on Wednesday last, and was the oldest member of the medical profession in Bath. Dr. Coates was a liberal supporter of the Bath charitable institutions. He was honorary consulting physician to the Royal School for Daughters of Officers of the Army, Lansdown, a trustee of Partis College, and also of Holburne Museum. He gave £1,000 to the Bath Blue Coat School and a similar sum to the Royal College of Physicians to found a prize. Dr. Coates became a Fellow of the Royal College of Physicians, Edinburgh, in 1857, and of the Royal College of Physicians, London, in 1873. He was formerly resident clinical assistant at the Hospital for Consumption at Brompton.

# SPECIAL ARTICLES.

# THE TYPHOID OUTBREAK AT CLONTARF.

SIR CHARLES CAMERON, Medical Superintendent Officer of Health for Dublin, has published, in the form of a Report to the Dublin Corporation, an interesting account of the outbreak of typhoid fever

which occurred last autumn at Clontarf.

which occurred last autumn at Clontari.

The area affected by the epidemic contained 748 houses; of these, 193 were supplied with milk from one dairy, and 555 from 28 other dairies; 82 of the houses were invaded by typhoid fever, and 127 of the inmates became victims of the disease; 79 of the 82 houses were supplied with milk from the suspected -that which supplied 193 of the houses. As to the other 3 houses, it was found that they also had occasionally received milk from the suspected dairy.

The milk from the dairy and specimens supplied by it to houses in Clontarf were examined bacteriologically, and no micro-organisms characteristic of typhoid fever were found in them. As Sir Charles Cameron points out, it is only rarely that typhoid bacilli are discovered in milk. The dairy was bacilli are discovered in milk. The dairy was examined and found clean and well-kept. The cows of the dairy numbered 58, of which 13 were within the curtilage of the dairy. The remainder were in pastures quite separate from it. The milk from the pastures was distributed direct to the customers, without being brought to the dairy itself. No member of the dairyman's family or staff had recently been ill, and it could not be found that any had ever had typhoid fever. On the suggestion of Sir Charles Cameron, the proprietor of the dairy obtained the services of a bacteriologist to examine all persons connected with the service of milk. The result of the examination was never made known to Sir Charles Cameron, but one of the men employed as milkers was subsequently transferred to other employment. Previous to this, the dairyman's solicitor had made an application to the Local Government Board to hold a sworn inquiry into the cause of the epidemic, but the Board declined. The solicitor subsequently applied to the King's Bench for a mandamus compelling the Local Government Board to hold the inquiry, but he withdrew the application. The withdrawal was made after the bacteriological examination had been carried out.

When satisfied that the outbreak appeared to be due to infected milk, the question arose: How should action be taken to restrain the sale of it? If a case of fever had been found in the dairy, or that any person connected with it was, or had been, recently ill, the Public Health Acts and the Dairies and Cowsheds Orders could be employed for the purpose. In the absence of any knowledge of disease in connection with anyone in the dairy. Sir Charles Cameron consulted the Law Agent of the Corporation on the subject. He was of opinion that in the existing state of the law no legal action could be taken. The Assistant Law Agent was of the same opinion.

The Local Government Board, however, and their advisers were of different opinion, and the Board advised the Corporation to take legal action against the proprietor of the dairy in order to stop the supply of milk. The opinion of senior counsel was taken by both parties, and no legal action ensued. The case submitted to counsel by the Law Agent of the Corporation contained the following query:

"In view of the fact that there was no direct evidence to show that the milk of this dairy caused and is causing the spread of typhoid in the district, can

the Corporation take any step to compel the owner to discontinue the supply of milk in the district of the City of Dublin?"

We entirely fail to see any justification in the facts, as Sir Charles Cameron recounts them, for the statement in this query. With such a case put before him in such a manner, it is hardly a matter of surprise that counsel advised against any action. Senior counsel consulted by the Local Government Board, on the other hand, remarked:

"The case is one of much difficulty and doubt, but my own opinion is that a court could, under the terms of the section, and would in the circumstances, construe the section so as to bring the case within it, having regard especially to the paramount object of the section, and of the entire Act being the preservation of the health of the community by preventing the spread of disease. I do not agree with counsel that the section must necessarily be construed in the very strict way in which he looks at it. It is entirely remedial as regards the public, though penal as regards the dairyman, and should be construed with reference to the true meaning and real intention of the legislation, which was to prevent the spread of disease.

By this time, of course, the outbreak had almost subsided, and no legal proceedings were taken.

During the investigations made by Sir Charles Cameron and Surgeon-Colonel Flinn, of the Local Government Board, it came to their knowledge that a case of illness, stated to be typhoid, had occurred in August in a house whose yard was in close proximity to the yard of the dairy. During August the discharges from the patient passed down a sewer made of stone. At a right angle from the sewer, a com-bined drain extended to the dairy premises. This drain had neither an interceptor nor a ventilator.

In the month of August, 1908, the sewer was opened near its junction with the drain, and a quantity of "black stuff" was taken out of the sewer and placed on the surface of the lane, where it remained for three or four days. This work was done by the Corporation workmen, or by contractors' men in connection with the main drainage works.

Sir Charles Cameron states his opinion that the outbreak was due to the infection of milk by a typhoid carrier, supposed to be one of the men employed as milkers. He believes that the alleged case of typhoid occurring in August had nothing to do with the out-break. We do not find his argument quite convincing. The theory that one of the milkers was a typhoidcarrier is an assumption, with no direct support except the alleged fact that he was removed to other work after being subjected to bacteriological examination. On the other hand, we have a case regarded by a medical man as typhoid, though not notified, in immediate proximity to the dairy-yard, where the vessels used for carrying the milk were washed. The drains were in connection, and unprotected, and in addition, for some length of time, the contents of the drains were exposed freely in the lane adjoining the dairy-It is true that there was an interval of some vard. weeks between the first exposure of the sewage material and the beginning of the outbreak, but the difficulty of explaining this interval is not as great as that of explaining why the milker should suddenly cause a fulminating outbreak. The milker is not said to have come recently into the employment of the dairy proprietor, and there is no reason to suppose that cases of typhoid had ever arisen from him before. In the history of most carriers we find several cases scattered over a period of years, and not one sudden outbreak. In fact, the only new feature in the history of the dairy was the probable case of typhoid close at hand, and the exposure of the sewage by the Corpora-tion workmen. We cannot understand why a dairyyard, subject to inspection, had been permitted to remain with an unprotected closet-drain, until the outbreak of typhoid drew attention to the condition.

The failure of the Corporation to take legal proceedings is insufficiently justified, the case for counsel's opinion being much less strongly stated than might with accuracy have been done.

# REVIEWS OF BOOKS.

COMMON AFFECTIONS OF THE LIVER. (a)

THE author, in his preface, explains that this work is a compilation of such notes as he had used for his clinical lectures, dealing with diseases of the liver, arranged in book form. He makes for it the modest claim that it is intended for students beginning their work, and not for those who have extensive clinical knowledge; yet, after reading it, we are left wondering what more of importance there is to say, and what the larger text-books contain which swells them to their more pretentious proportions. After a brief account of the anatomy of the liver, and of displacement of that organ, the subject of jaundice is fully dealt with. Here we notice that no attempt is made to adhere to the old division into obstructive and non-obstructive jaundice, but causes of obvious obstruction are first given in the order of the frequency of their occurrence, and afterward the causes of less obvious obstruction. In this way the old clinical distinctions remain, whilst the arrangement clinical distinctions remain, whilst the arrangements is accurate in accordance with more recent experimental work. Further on, 34 pages are devoted to a description of large single abscess in the liver, a somewhat large section of the work, considering the comparative rarity of this disease in England. Whilst all will agree with the author when he states that in a case of uncomplicated hepatic abscess the pus should be let out, we think that his teaching in respect to an abscess which has ruptured into the lung will be less generally accepted. His advice is to let well alone, and not interfere unless there is indubitable evidence

that the patient is losing ground.

This is followed by an especially useful chapter on suppuration about the liver, in which the author shows his close acquaintance both with the practical side of the subject and with the late Mr. H. L. Barnard's work on subphrenic abscess. We note that he uses the truth that subphrenic abscess is equally common in the two sexes as evidence in favour of his contention that gastric ulcer is equally common in men and women. Here, again, in the matter of treatment we think there is room for difference of opinion. Many would not agree that a subphrenic abscess should be left unexplored for 14 days after it had been suspected. A great point is made of the important clinical sign that the liver is not displaced downwards in this condition, for it is mentioned in at least four places (pp. 10, 107, 121, and 125), but this is only partly true, for, as Mr. Barnard has said, in the right extra-peritoneal variety it may be displaced downwards as far

as the umbilicus.

The next section, which concerns cirrhosis of the liver, contains many original and interesting suggestions. Hypertrophic cirrhosis is regarded as an early stage of the atrophic form, and not, as some authors believe, as a distinct variety. It comes somewhat as a surprise to learn, on p. 147, that piles are uncommon in cirrhosis of the liver. The author makes a good case for ascribing the ascites to the action of a toxin, and not, as is usually supposed, to portal obstruction, and he emphasises the gravity of this symptom by stating that patients in whom it occurs usually die in a few weeks. Under treatment, he says, "unless the quantity of fluid is so great that it hampers the movements of respiration or a the total of the contraction of the co the movements of respiration or pushes the heart out of place, there is nothing to be gained by letting it out." This teaching is directly opposed to that of certain other authorities, one of whom advised, in a recent Lumleian lecture, that ascites in such cases should be tapped early and often. This difference of opinion is probably due to the recognition or otherwise of the individuality of perihepatitis, on which the author lays so much stress. No instruction is given to see that the bladder is empty before inserting the trochar. In the chapter on perihepatitis, the author summarises his work on the subject, and states his well-known views.

The last 80 pages contain, besides sections of less clinical importance, an account of malignant disease

of the liver and of hydatid cyst. The sections dealing with fatty liver, lardaceous liver, and tubercle and actinomycosis of that organ, are necessarily largely pathological, rather than clinical.

This volume should prove of great value, not only to the beginner, but to the more advanced student, for it contains in a very readable form all that is of practical use in the recognition and treatment of hepatic

FARABEUF ON MIDWIFERY. (a)

BRITISH obstetricians will extend a very hearty welcome to the new edition of this well-known textbook. There are few books on obstetrics whose drawbook. There are few books on obstetrics whose drawings have been so profusely reproduced by other writers, and whether this is done, as Professor Farabeuf says, "avec indication de leur origine ordinairement, ce qui est bien," or "mais pour toujours, ce qui est mal," the welcome the book will receive is the same.

In the present edition the text and the drawings have been increased. As before, the book only deals with certain subjects in midwifery, and not with the whole of midwifery. The selected subjects are—anatomy, presentations and positions, mechanism of labour, vaginal examination, extraction of the breach. version, and delivery by the forceps. It is easy to-understand that Professor Farabeuf did not wish to include the remainder of midwifery, but there is one omission for which it is difficult to account, namely, the omission of all reference to abdominal palpation and auscultation. This is the more strange as there is a long section devoted to vaginal examination. It is unnecessary to advise any one who has read former editions of Professor Farabeuf's work to read this edition, for they will do so without advice. As for those who have not read them, we can only advise that they make haste to add another span to the stature of their obstetrical knowledge.

ON SPRUE. (b)

The little that is known regarding this disease is only to be found scattered throughout the various medical journals. A monograph on the subject is therefore a desideratum. The volume under review, after dealing fully with the history and literature of sprue, goes on to discuss the symptoms and signs of this disease, which seems to be on the increase in Eastern tropical countries. The morbid anatomy and pathology of the disease are very carefully and fully considered. The author states that the exact pathology of the disease is probably "a specific protozoan or bacterial infection, which gradually spreads from above downwards through the alimentary canal." As yet, of course, no specific organism has been discovered in the lesions or in the blood of patients suffering from sprue, but this does not interfere with the author's explanation as to the actual origin of the disease.

Dr. Carnegie Brown deals at considerable length with the general effects of a milk diet in the treatment of sprue. He says this form of nourishment merely serves to keep the patient alive. It does not check tissue waste, which still goes on. In spite of all this, the use of a milk diet appears to be indispensable. Along with milk, strawberries give good results. The latter should be given as early as possible in the disease. Where fresh milk cannot be obtained, an exclusive meat diet is said to afford very good results. Treatment by means of a purely fruit diet is also referred to the control of the disease. to very fully, as is also the treatment of the disease by means of drugs. The management of complications and collateral infections is dealt with in a very careful and practical manner. In the treatment of sprue alcohol is strongly condemned by the author. There exist "from the earliest to the latest stage of the disease a specific intolerance and antagonism to alcohol in any form."

(a) "Introduction à l'étude clinique et la pratique des Accouchements." Par le Professeur L.-H. Farabenf et le Docteur Henri Varnier, Préface du Professeur A. Pinard. Dessins démonstratife de L.-H., donnant avec les répétitions nécessaires 375 figures dont plusieurs nouvelles. Nouvelle édition revue et augmentée. Pp. viii and 488. Paris: Steinheil, Editeur. 1908.

(b) "Sprue and its Treatment." Bv W. Carnegie Brown. M.D., M.B.C.P. London: John Bale, Sons and Danielsson, Ltd. 1908.

<sup>(</sup>a) "Common Affections of the Liver." By Wm. Hale White, M.D. Lond., F R.C.P., Senior Physician to Guy's Hospital. London: James Nisbet and Co., Ltd. 1909.

The writer insists on the necessity of early treatment, and altogether affords the reader all the information regarding the mode of dealing with this disease which has been collected up to the present time. The book is essentially a practical one, and will doubt-less become the standard work on its subject in the English language. For medical men practising in the Tropics Dr. Carnegie Brown's monograph will be found of very great assistance as a guide to the management and treatment of this somewhat troublesome affection.

DIET IN INFANCY. (a)

This is a well-thought-out little book on the dietetics of infancy and the management of digestive disturbances, and it goes a good deal farther than most works of the kind. The author is very dogmatic, and one feels disposed at times to challenge the statements he makes with such confidence. Has it really been proved, for instance, that boiled milk is less digestible than raw? In any case, there is good authority for the contrary view. Not, however, that this point has any practical bearing on the author's teaching, because he advises the sterilisation of milk all the same. It is all very well for him to instruct us not to give infants milk obtained from "Jersey, Guernsey, and Alderney breeds of cows," but how in the when the second of the second but how is the urban practitioner to discriminate? discussing the employment of condensed milks for infant feeding, of which he approves, the author does not evince any preference for the unsweetened varie-ties—the "Ideal" milk, for example, yet most writers on the subject admit that the presence of so large a proportion of sugar is a drawback.

No doubt it is desirable to keep milk at a temperature below 45° F. until consumed, but it is hardly practicable in most instances, so that boiling and rapid

cooling become indispensable.

The author goes over the ground methodically, and practitioners will not refer to him in vain when in a difficulty. There are some seventy pages of appendices, mostly reprints from medical journals on subjects germane to infant nutrition.

INTERNATIONAL CLINICS. (b)
This volume of "International Clinics" contains twenty-four separate papers, dealing with various subjects of interest in connection with Medicine, Surgery, Therapeutics, and several of the specialities. A careful and useful compilation of cases of "Acute Dilatation of the Stomach" is contributed by Dr. Albert Nicholls, and is introduced by a description of some cases that have come under the writer's own observation. He points out that the most constant feature post-mortem, in addition to the actual gastrectasis itself, is the presence of duodenal obstruction caused by the root of the mesentery. This obstruction he regards as the actual cause of the dilatation, and strongly recomactual cause of the dilatation, and strongly recommends, in consequence, the adoption of a postural method of treatment. Other subjects dealt with under the heading of "Treatment" and "Medicine" are:—"Primary Splenomegaly," by Parkes Weber; "Physical Therapeutics," including a plea for their more extended use in clinical teaching hospitals; "Enteroptosis," "The Treatment of Gastric Ulcer," and "Psycho-therapeutics." A useful paper in the section devoted to Pædiatrics is that on "The Serum Treatment of Epidemic Cerebro-Spinal Meningitis," by Dr. Hunter Dunn. The history of this method of treatment is briefly traced, and the rationale of the method in is briefly traced, and the rationale of the method in its entirety is discussed. Flexner's serum, of course, receives most attention, and a statistical analysis of the cases treated by it is presented. The Surgical section contains five articles dealing with a variety of subjects. Ely contributes his personal experiences with Bier's treatment by passive hyperæmia, and expresses his warm commendation of this therapeutic means. McGregor discusses "Traumatic Lesions of the Semilunar Cartilages and their Treatment." He regards operative measures as alone likely to be

attended with a successful result. Papers on "Fracture of the Skull," on "Pneumococcic Arthritis," and on "Paronychia Lateralis" complete the series. In the other sections the following papers may be noticed:—"Pseudo-Bulbar Paralysis," with account of a typical case, by Dr. Lloyd; "The Rôle of Insects in the Transmission of Disease," by Dr. Brown; and an interesting article on "Bronchial Calculi," hy Clifford Farr. The entire volume forms a collection of readable and interesting practical papers.

YEO'S MEDICAL TREATMENT. (a)

The appearance of a new edition of this extremely popular manual of treatment entails little responsibility upon the reviewer. All that is required by the medical world is the information that the twenty-second thousandth has been reached, together with a brief notice of any fresh features in the work. The third edition came out as recently as 1902, but the rapid growth of medical knowledge has rendered a thorough revision necessary, in which the author has been assisted by Dr. Raymond Crawford and Dr. Farquhar Buzzard. The former has undertaken the parts of the book dealing with diseases of the circulation and digestion, together with those of the liver and kidneys, while the latter has naturally dealt with the nervous system. The peculiar charm of this book lies partly in its admirable literary style, and partly in the system which invests therapeutics with all the essential factors of interest involved under such allied questions as pathology, ætiology, and clinical characters. The present presents an advance on former editions and its general form and appearance, it is hardly needful to add, are above reproach.

# LITERARY NOTES.

THE ninth edition of Dr. E. J. Domville's little "Manual for Hospital Nurses" shows that this meritorious little work has been duly appreciated by those for whom it was written. The text is clear, brief, and to the point, and the whole ground of the nurse's duties is adequately covered.

THE fifteenth edition of Dr. Thomas Linn's "Health Resorts of Europe" displays a healthy tendency to put Resorts of Europe" displays a healthy tendency to put on flesh, short of obesity, and it constitutes a handy guide to the principal health resorts and watering-places of Europe, including Great Britain. We have the hotels and "pensions," lists of doctors and dentists, hints as to amusements, and a reference list of works for the health of these who desire detailed informafor the benefit of those who desire detailed informa-

VERY opportunely at the present moment comes a series of lectures delivered at the West London Post Graduate College on the "Medical Inspection of School Children." The first deals with the general scheme such instructions should take, and the others with examination of the skin, eyes, ear, throat, and nose, and the teeth, by members of the West London Hospital Staff. The information, if elementary, is pleasantly conveyed, and is sound so far as it goes.

MESSES. EVANS, GADD AND Co., Ltd., have issued a little book on "Drugs and Medical Requisites," which is a good deal more than a trade catalogue. It contains a great deal of information of a varied character, and much of it is very useful. The list of synonyms of the trade and scientific names of drugs is instructive. We confess we did not know that pil. colocynth et hydrarg, went by the name of "Abernethy's pills," and several other facts here mentioned.

SIR JAMES SAWYER'S Lumleian Lectures on "Points of Practice in Maladies of the Heart " (Birmingham: Cornish Brothers, Ltd.) were well worth reprinting.

(a) "A Manual of Medical Freatment," By I. Burney Yeo, M.D., F.R.O.P., assisted by Raymond Crawford, M.D., and E. Farquher Buzzard, M.D. New Edition. Two Vols, London and New York: Cassell and Co., Ltd. 1999.

<sup>(</sup>a) "Diet in Infancy." By A. Dingwall-Fordyce, M.D., F.R.C.P.Ed., Estra-Physician to the Royal Hospital for Sick Children, Edinburgh. Edsburgh: Wm. Green and Som. 1968. (b) "International Chisics." Vol. IV. Eighteenth Series. Phila-delphia and London: J. B. Lippincott Co. 1908.

The subject of cardiac disease is discussed from the clinical point of view, and special emphasis is attached to the particular observation of individual cases. are enjoined not to attach overweening importance to stethoscopic examination, a heart case has never been a heart case only; indeed, as physicians, we are much more concerned with the physiological effects of a cardiac state than with the merely local manifestations of the lesion. There is nothing didactic in these lectures; they are chatty observations on points of importance in diagnosis, and diagnosis of heart lesions viewed from the general physician's point of view. Hackneyed as is the subject, no practitioner could peruse the author's thoughtful remarks without adding to his knowledge of the subject.

# MEDICAL NEWS IN BRIEF.

#### The New Physiology Buildings at University College.

THE new Institute of Physiology, although not yet opened officially, was inspected on Saturday last by the members of the Physiological Society, who were enthusiastic as to its capabilities for teaching and for research work. Its usefulness will also be greatly increased when the college authorities have erected two similar buildings beside it—one for the study of anatomy and the other for the study of pharmacology, which enters into the present design.

The laboratory consists of four storeys, and includes

a large lecture-room, capable of accommodating 200 students, without discomfort, and equally large rooms for the study of physiology, of physiological chemistry, and of histology. The special features of the laboratory are, however, the large number of smaller rooms intended for the purpose of research and the theatre has been so constructed that students will be able to see the full details of important demonstrations.

An operation-room has also been built, in which it will be possible to observe the conditions of absolute cleanliness that are essential; adjacent to it is a bathroom, and on the same floor is an animal hospital, where the very best conditions for recovery can be maintained. A special room on the ground floor has been reserved for the purposes of micro-photography. Other features in which the convenience and comfort of both elementary and advanced students have been specially considered have entered into the plans, and the new buildings will greatly enhance the teaching facilities of one of London's most popular medical

# The Nurses' Registration Bill (No. 2).

A SHORT résumé of the Bill introduced by Mr. Findlay, and known as the Nurses' Registration Bill, No. 2, may be of interest to our readers, as it differs in many respects from the Bill on the same subject introduced by Mr. Munro Ferguson. Bill No. 2 proposes to set up a Central Board for the registration of nurses in the United Kingdom, which is to consist of 27 persons. A large element on the Board will consist of matrons of hospitals and nurses, or persons selected by them. A registered medical practitioner, according to the scheme of the Bill, will be appointed by each of the following bodies: the Privy Council, the General Medical Council, the Medico-Psycholo-gical Association, and the Central Hospital Council. The registered nurses of the United Kingdom are to elect a medical man, and three medical practitioners are to be appointed by the British Medical Association. A provisional constitution is provided for in order that certain initial work may be carried out.

The proposed duties and powers of the Central Board are set forth as follows:—"(1) To frame rules— (a) regulating its own proceedings and the times for holding its meetings; (b) regulating the issue of certificates of registration and the conditions of admission to the register of nurses; (c) regulating the course of training and conduct of examinations and the remuneration of the examiners; (d) regulating the admission to the register of persons already in practice as nurses at the passing of this Act; (e) deciding the conditions under which a nurse may be suspended from practising as a registered nurse; (f) defining the particulars required to be given in any notice under this Act. (2) To appoint examiners and inspectors.
(3) To decide upon the places where, and the time when, examinations shall be held. (4) To publish annually a register of nurses containing the names, addresses, and record of training and work of nurses who have been duly registered under this Act. (5) To decide upon the suspension or removal from the register of the name of any nurse for disobeying the rules and regulations from time to time laid down under this Act by the Central Board from conduct disgraceful in a professional aspect, or for other misconduct, and also to decide upon the restoration to the register of the name of any nurse so suspended or removed. (6) To take proceedings against persons guilty of offences under this Act. (7) To issue and cancel certificates of registration, and generally to do any other act or duty which may be necessary for the due and proper carrying out of the provisions of this Act. All rules framed under this section shall be valid only if approved by the Privy Council."

Provision is made for the registration of existing nurses, but at the expiry of three years the Bill proposes that admission to the register should only gained by persons who produce evidence satisfactory to the Central Board of training in the wards of an approved hospital or Poor-law institution, and pass the examination prescribed by the Board, as well as complying with other requirements.

#### A Doctor's Operation on Himself.

AT Newsham, Northumberland, on March 20th, an inquiry was held into the death of Dr. Ephraim Henderson, aged 35, who lived at Newsham. He became seriously ill on March 17th, and on March 18th, during the absence of his wife and a nurse, he inflicted a wound in his throat with a knife. He died the same

Dr. Cromie, of Blyth, said Dr. Henderson had been in his service nearly three years. On March 17th the witness was called to see him, and found he was suffering from Bright's disease of long standing and septic pneumonia. With regard to the wound in the throat the witness said it had evidently been made by Dr. Henderson for the purpose of relieving himself from the pain of his other troubles. The position of the wound, the witness urged, supported the theory that Dr. Henderson did not contemplate suicide. anything the wound in the throat prolonged his life by causing hæmorrhage upon the lungs. Dr. Cromie added that he was of opinion that death was due to Bright's disease, accelerated by septic pneumonia.

The jury accepted Dr. Cromie's explanation of the wound, and entered a verdict to the effect that death was due to natural causes.

### Death Under Chloroform.

An inquiry was held by the Wigan Borough Coroner, on March 16th, as to the cause of the death of Rhoda Howard, aged 22 years, which occurred at the Wigan Infirmary, at 1.30 p.m., on Sunday, after an operation had been performed on her for contracted knee-joints, for which she had been chloroformed.

Benjamn Howard, father, a jobbing gardener, of Back Lane, Shevington, said the deceased had not been in a very good state of health all her life. About six years ago she burst a blood vessel, in consequence of

which she was afterwards unable to walk.

Dr. Buchanan, surgeon at the Wigan Infirmary, stated that deceased was admitted to the infirmary on February 24th, suffering from contracted knee-joints, and it was necessary to straighten the knees with the patient under chloroform. Witness administered the chloroform, and he and Dr. Berrie performed the operation.

The Coroner: In what quantity was the chloroform administered?—I should say altogether there was used about a little over an ounce. Of course, we used the open mask, and with this the largest part of the snæsthetic evaporates in the air.—Before administering the chloroform was she examined?—I examined the heart, and I thought it was all right; I did not recognise anything wrong with it.

Further questioned, witness said that after the operation had been performed; and about a quarter of an hour after he had administered the chloroform, the deceased collapsed, and he and Dr. Berrie resorted to artificial respiration, which they kept up for a little

over half an hour without effect.

The Coroner: Have you had considerable experience in administering anæsthetics?—I have given them about thirteen or fourteen hundred times. I have never had a death.-And the patient's heart may be in a certain condition, which cannot be detected previous to the administering of the anæsthetic, and result in a collapse?—That is so.

What was the cause of death?-I think it was due

to cardiac failure under chloroform.

The jury returned a verdict that deceased died from heart failure under chloroform.

#### Cardiff Doctor's Sudden Death.

MR. W. L. YORATH held an inquiry at Cardiff on March 18th into the death of Dr. William Patrick Brooks, of 10 Constellation Street, a well-known Cardiff medical practitioner, who expired suddenly.

Mrs. Norah Brooks, the widow, stated that the de-

ceased was 39 years of age, and for the past few years had enjoyed fairly good health. On the Sunday evening he had a fit, but soon got out of it. He did not sleep that night, and was not well on Monday. In the evening he took a draught, and was much better on Tuesday. The next morning he complained of being unwell, and stayed in bed. Towards mid-day sent for, but her husband died just before he arrived.

In answer to the Coroner, Mrs. Brooks said the

deceased drank, but never to excess.

Dr. Macgregor, giving evidence, said that he was sent for, and upon his arrival found the deceased had been dead just a few minutes. There were no marks of injuries, and he could not find any trace of drugs. Death was due to heart failure, perhaps following upon the fit which the deceased had on Sunday.

The jury returned a verdict in accordance with the

medical evidence.

## Lener Worker's Death.

THE death is announced of Dr. Smith, the physician at the Tracadie Leper Colony in the Bay of Fundy, after a lifelong work as the volunteer medical attendant of the unfortunate lepers. The colony was originated about the year 1850, when the passengers of a British ship, who developed the disease, were forced to disembark at that point.

#### Sentences for Abortion.

AT Bristol Assizes, on March 26th, before Mr. Justice Ridley, Soloman Fry, 48, a mason, and Sarah Ann Wright, 35, a charwoman, were indicted for the murder of Kate Webster on October 27th last in

murder of Kate Webster on October 27th last in Bristol. No evidence was offered by the prosecution, and a verdict of "Not guilty" was returned.

The same prisoners, together with Clara Lennard, of no occupation, were then indicted for procuring abortion. All pleaded "Guilty."

It appeared that they had carried on the practice for years, and sums varying from 5s. to a sovereign had been paid to them by women. There were 14 cases in Bristol alone against Fry, besides the eight charges preferred against him in the present indict. charges preferred against him in the present indict-ment. Wright was a married woman. The prisoner Lennard was the wife of a collier, and was known as "a married woman's friend," and for seven years had acted as an introducer, but had not actually performed any operations.

Wethered, who appeared for Lennard, stated that she stood on a different footing from the other prisoners. Fry had been originally a respectable and hard-working stone-mason.

Mr. Inskip, who defended Wright, urged that she was respectable until she became acquainted with Fry. Mr. Justice Ridley said that Lennard, who was the mother of six children, and was enceinte, must go to prison with hard labour for 12 calendar months. Wright would be kept in penal servitude for seven years, and Fry must go to penal servitude for 12 years.

#### Medical Sickness and Accident Society.

At the usual monthly meeting of the Executive Committee of this Society, Dr. de Havilland-Hall in the chair, it was reported that the business for the early part of this year was satisfactory. The number of sickness claims received had been large, but on the whole the sickness experience was rather lighter than for the same period of 1908. The number of new entrants is also quite satisfactory, being well above the average, though rather less than in the corresponding period of last year. As no money is paid by the Society as commission, and no agents are employed, the ever-growing number of new entrants is satisfactory evidence that the benefits offered by the Society are appreciated by the profession. Prospectuses and all further particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33 Chancery Lane, London.

#### Destruction of the Irish "Tuberculosis" Van.

WE regret to learn that the "Tuberculosis Van." which was started in connection with the tuberculosis campaign of the Women's National Health Association, has been destroyed by fire at Lifford. was on tour in the north of Ireland at the time, and was on tour in the north of the last had been visited by 70,000 people. Unfortunately, now, all charts, exhibits, literature, and apparatus of various kinds have been destroyed. We understand that a fund has been established with the object of re-starting the van.

#### Conjoint Examinations in Ireland.

The following candidates have passed the Preliliminary Examinations of the Royal College of Physicians and the Royal College of Surgeons, March, 1909:—S. J. Moore Cairns, F. F. B. Darlye, J. J. Delany, G. S. Douglas, M. Fitzgibbon, W. A. N. Fox, C. E. H. Gater, W. O'C. Hunt, W. G. Keys, W. A. Malone, W. Morrow, R. P. Weldon.

#### Trinity College, Dublin.

Trinity College, Dublin.

THE following candidates passed the Intermediate Medical Examination, Hilary Term, 1909:—Part I.—Arthur Chance, Frank Crosbie, Oswald C. S. Tandy, Gerald G. P. Beckett, Hubert G. Holdbrook and William A. Taylor (&q.), Samuel A. Lane, Ronald G. M'Entire, Leonard Shiel, James C. Kelly.

Final Medical Examination.—Part II.—Midwifery.—Thomas A. Hughes, Douglas M. Moffatt, and Cecil P. Smyly (passed on high marks), Henry R. Kenny, William P. H. Smiley, Desmond Drew, Joseph P. R. Poch, Brindley H. Moore; Wellesley R. Allen, Charles G. S. Baronsfeather, and Peter H. Lemass (&q.); Denis J. Stokes, Wallace D. Mitchell, Hugh S. Metcalfe, Joseph E. N. Ryan.

# Indian Medical Service.

THE following appointments were officially gazetted on Friday last:

Lieutenant-Colonels to be Colonels.—C. F. Willis, M.D., Nov. 14th, 1908, and W. A. Corkery, Jan. 1st,

Captains to be Majors.—J. M. Woolley, M.B.; C. A. Lane, M.D., T. B. Kelly, F.R.C.S.E.; W. H. Kenrick, C. H. Watson, E. F. E. Baines, G. O. F. Sealy, S. Anderson, M.B.; F. H. G. Hutchinson, M.B.; J. L. Marjoribanks, A. Fenton, M.B., and R. W. Knox,

Marjoribanks, A. Fenton, M.B., and R. W. Knox, M.B., Jan. 28th, 1909.
Lieutenants to be Captains.—E. J. C. McDonald and W. D. Wright, M.B., Sept. 1st, 1908, H. W. Pierpoint, F.R.C.S.; Khandu Ganpatrao Gharpurey, W. D. H. Stevenson, M.B.; H. P. Cook, M.B.; W. J. Fraser, M.B.; D. C. V. FitzGerald, R. S. Kennedy, M.B.; B. Higham, M.B.; C. A. Godson, R. H. Lee, M.B.; P. Heffernan, M.B.; H. S. Hutchison, M.B.; R. G. G. Croly, M.B.; S. T. Crump, W. B. A. K. Cullen, M.B., and J. MacGregor Skinner, M.B., Feb. 1st, 1900. Feb. 1st, 1909.

To be Senior Assistant Surgeon, with the honorary rank of Captain.—Senior Assistant Surgeon, with the honorary rank of Lieutenant, E. W. Fraser, honorary rank of Lieutenant, E.

Jan. 12th, 1909.

To be Senior Assistant Surgeon, with the honorary rank of Lieutenant.—First-Class Assistant Surgeon H. W. De Lanty, Jan. 12th, 1909.

# OF RECENT MEDICAL LITERATURE. SUMMARY ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

Differential Diagnosis and Surgical Treatment of Chronic Spinal Meningitis .- Sir Victor Horsley (Brit. Med. Journ., February 27th, 1909) uses the records of 21 cases on which he has operated in discussing chronic spinal meningitis. He states it is certainly more common than tumour of the spinal cord, though it presents the same symptoms—except certain minutiæ—and is usually diagnosed as the tumour. The condition yields to surgical treatment, when ordinary medical treatment has failed. The class of cases which the author refers to under the above name are those in which an adult person—only one case being seen below the age of puberty—begins to complain of pain and progressive loss of power in the legs, with, it may be, also slight kyphotic curvature of the spine, and developes ultimately a progressive paraplegia that runs through the ordinary course and terminates fatally. The first case treated by the writer was sent to him as compression paraplegia, following supposed caries of the spine. At the operation the theca of the cord was found to be enormously distended and filled up the lumen of the canal. opening the theca, nothing but a very considerable excess of cerebro-spinal fluid was found, and a cord that was rather shrunken. No compression was found by passing a probe 5 or 6 inches up and down the neural canal. This patient was getting worse under by passing a probe 5 or 6 inches up and down the neural canal. This patient was getting worse under antisyphilitic remedies and every other kind of drug treatment, but the progress of the disease was completely stopped by laminectomy, freely opening the theca and washing out with mercurial lotion. Some typical cases are described. A dressmaker, soon after typical cases are described. A dressmaker, soon after a severe attack of influenza six years ago, commenced to complain of pain in the right loin, worse on movement, and a feeling as if the muscles of the thigh were tightening. Later painful cramping and twitching of the right leg occurred. Ultimately the pain affected the whole of the right leg, having commenced in the right groin. This point is the most valuable among the minutiæ which serve to distinguish these cases from cases of spinal tumour, in which the pain is usually localised to one nerve root. On admission, this woman was very stout and healthy-looking, with no indication of any disease above the umbilicus. There was slight wasting and weakness of the whole of the mucation of any disease above the unbilicus. There was slight wasting and weakness of the whole of the right leg. She had relative anæsthesia of the whole of the right limb and of the right hypochondriac region, the anæsthesia being of all forms of sensation, as well as relative analgesia. The deep reflexes were diminished on both sides aspecially the right. as well as relative analgesia. The deep follows well diminished on both sides, especially the right. Superficial reflexes were diminished. There was slight dribbling after micturition. There were no trophic lesions in the skin, which is a most important point between the level of the dorest of t in these cases. On operating at the level of the dorsal segment a marked degree of spinal meningitis was found and relieved with excellent results. The author draws particular attention to the degree of unilaterality found in these cases, which unilaterality has also been verified in two autopsies. The prognosis in these cases depends on the age of the patient; if at or before middle-life, it is likely to be very good; if beyond middle life, it is likely to be very good; if beyond middle life, it is likely to be very poor. The oldest patient operated on was 60 years of age, and did not improve in the least. It was a bad case, and there was a great deal of pachymeningitis, and there was a depressing history of congenital syphilis. The author considers that the condition is probably due to syphilitic, and very likely also to gonorrhæal, infection.

Case of Carcinema of the Stemach Occurring in a in these cases. On operating at the level of the dorsal

Case of Carcinoma of the Stomach Occurring in a Boy Aged Fourteen Years.—Ness and Teacher (the Brit. Journ. of Children's Diseases, December, 1908) record a case of carcinoma of the stomach occurring in a boy, æt. 14. The patient had complained of pain in the abdomen for some time before his admission to

hospital, and had suffered from marked jaundice for about two months. Shortly after admission a distinct tumour could be felt in the abdomen, and the boy developed ascites. An exploratory abdominal secboy developed ascites. An exploratory abdominal section was done, and several tumour masses were found in the abdomen, the gall-bladder was distended, and as the tumour could not be removed an anastomosis was effected between the gall-bladder and the duodenum. The patient died about a week after the operation, and at the post-mortem examination the following condition was found in the stomach:—"In the lesser curvature, a short distance from the pylorus, there was an ulcer about three millimetres in diameter." It was approximately circular in outline, with thick edges. It appeared to be a simple chronic ulcer, but there was an unusual degree of thickening of its margins and a considerable area of the stomach wall around it was also thickened and extremely hard. White hard masses extended from the outside of this area to the liver and gall-bladder, and there were numerous small white nodules in the peritoneal coat, and the gastro-colic omentum was full of similar nodules. Masses of tumour were also found at the root of the mesentery and extending through it. On histological examination the tumour was found to be a scirrhous carcinoma, with an extreme degree of fibrosis of the stroma and atrophy of the epithelial elements. Dr. Ness has only been able to find records of 19 cases of carcinoma of the stomach occurring in

persons under the age of 20 years. K.

The Natural Cure of Cancer.—Handley (Brit. Med. Journ., March 6th, 1909) publishes a highly suggestive lecture on the manner in which the organism tends to inhibit cancerous growths, or rather on the manner in which the growth tends to its own destruction. Instead of regarding, as has been usual, the degenerative process of regarding, as has been usual, the degenerative process as a mere accident of tumour-life, he regards it as an essential part of the process. "Every aggregation of carcinoma-cells has a definite life-cycle, and, after ircreasing in size for a varying period and at a varying rate, tends spontaneously to undergo degeneration and fibrotic changes. These changes extend from the centre of the mass centrifugally to its periphery, lead to its shrinkage, and terminate in the replacement of the aggregation of cancer cells by a fibrous scar." He shows that the known process of repair in cancer is a perilymphatic fibrosis which follows rapidly on lymphatic infiltration. Where the repair keeps pace with the infiltration, atrophic scirrhus occurs, where the infiltration is more rapid, there is medullary cancer. He shows, too, that in the spread of cancer as shown by the appearance of cutaneous nodules the earlier or central nodules tend to disappear as the circle widens. Two photographs of the same patient at different stages show this very clearly as regards cutaneous nodules on the abdomen. Handley offers, too, an explanation of the disappearance of the cancercell at the middle of the cancerous growth. "The epithelial cell is an obligate parasite upon the connective tissue cell." In other words, the epithelial cell, in his opinion, draws its nutriment, not from the blood, nor evn directly from the lymph, but from the lymph through the intermediation of a connective tissue cell. There is much in normal physiology, as well as in pathology, to support this view. In a cancer it follows that when the connective tissue cells have disappeared, that when the connective tissue cells have disappeared, the cancer cells must themselves undergo degeneration. We regret that space does not permit us to give Handley's arguments in fuller detail. Like all his writings on cancer, the lecture deserves the most careful perusal.

It is proposed to present Sir Felix Semon with a testimonial from his friends and admirers on the occasion of his approaching retirement.

# NOTICES TO CORRESPONDENTS. "Se: "

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," Old Subscriber," etc. Much confusion will be spared by attention to this rule.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12. Messrs. Dawson and Sons are our special agents for Canada.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be suthenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

Mr. W. STCART-LOW.—Your cases of "Malignant Disease of the

MB. W. STCART-LOW.—Your cases of "Malignant Disease of the Naso-pharynx" are marked for early insertion.

Naso-pharynx" are marked for early inserticn.

PRIMISIS.—Read the interesting memorandum recently issued by the Medical Officer to the Local Government Board. You will there find an account of the administrative measures which may be taken by sanitary authorities with their present powers. It is especially to be noted that those authorities have power to huild sanatoriums for tuberculosis, and that, without going to that expense, they can utilise their present isolation accommodation, when not needed for zymotic diseases, for the reception of tuberculous patients for educational treatment.

Ornea—We are obliged for the newspaper cutting. The

OMEGA.—We are obliged for the newspaper cutting. The matter has been dealt with in our editorial columns.

T. R. (Taunton).—It is a curious fact, and one upon which the public may be congratulated, that sheep are hardly ever known to be tuberculous.

GENERAL PRACTITIONER (Leeds).—It has been pointed out by Hertal that one of the signs of pregnancy consists in the development of fine downy hair over the entire body, and a remarkable stimulation of the hair follicles, by which rapid growth of hair in the hairy parts of the body ensues.

RESPICE FIREM (Bristol).—No ethical question is involved in the case to which our correspondent refers.

# Meetings of the Societies, Tectures, &c.

WEDNESDAY, MARCH 518T.

MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Chenics Street, W.C.).—4 p.m.: Mr. R. Johnson: Olinique (Surgical).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tettenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whiphaim); Skin (Dr. G. N. Meachen); Out-patient (Dr. T. R. Eye (Mr. R. P. Brooks).

TRURSDAY, APRIL 18T.

SONTOEN SOCIETY (20, Hanover Square, W.).—8.15 p.m.: Mr.

H. Gardiner: The Origin, History, and Development of the

X-Ray Tube.

NORTH-EAST LONDON CLINICAL SOCIETY (Prince of Wales's Hospital, Tottenham, N.).—4.15 p.m.: Discussion on Empyema (opened by Dr. T. R. Whipham).

ROYAL COLLEGE OF PHYSICIANS OF LOSDON (Pall Mail East).—5 pm.: Prof. C. S. Sherrington: The Role of Reflex Inhibition in the Co-ordination of Muscular Action, (Oliver-Sharpey Lectures.)

MEDICAL GRABUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical)

In the Co-Druinstoid of College and Polyclinic (22 Omenies Medical Graduates College and Polyclinic (22 Omenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—230 p.m.: Gynecological Operations (Dr. A. E. Glies). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. G. P. Chappel).

ROYAL Society of Medicine (Larinoological Section) (20, Hanover Square, W.).—5 p.m.: Cases: Dr. J. Dundas Grant: (1) Case of Retro-bulbar Neuritis, probably attributable to Sphenoidal Disease; (2) Case of Swelling over Superior Maxilla due to Angeio-neurotic Œdema; (3) Case of Rhinitis Caseoss. Sir Felix Semon, K.C.V.O.: Additional Note on Case of Malignant Disease in Left Pyriform Sinus, shown on Nov. 6th, 1908, and Feb. 1th, 1909. Mr. Stuart-Low: Case of Thyroid Tumour at the Base of the Tongue exhibited at the last meeting, now shown After Removal, with Specimen, Microscopic Slide, and Illustrations.

NEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith Road, W.).—8 p.m.: Clinical Evening.

Cases.

ROYAL COLLEGE OF PHYSICIANS OF LOYDON (Pall Mall East).—
5 pm.: Prof. C. S. Sherrington: The Role of Reflex Inhibition in the Co-ordination of Muscular Action. (Oliver-Sharpey Lectures.)
MEDICAL GRADVATES' COLLEGE AND POLITICIAN: (22 Chemies Street, W.C.).—4 p.m.: Mr. E. Clarke: Clinique (Eye).
NORTH-EAST LONDON POST GRADVATE COLLEGE (Prince of Wales's General Hospital. Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds) Clinics: Medical Out-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A. G. Auld); Rye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. A.

# Appointments.

BLAXLAND, A. J., M.B., B.S.Lond., Honorary Assistant Surgeon to the Norfolk and Norwich Hospital.

BUCHAN, George F., M.B., Ch.B. Glagg., D.P.H.Camb., Medical Officer of Health of the Urban District of Heaton and Inleworth, Hounslow.

CANNEY, J. R. C., M.B., B.C., L.B.C.F.Lond., M.B.C.S., House Surgeon at University College Hospital.

HEWELEY, FRANK, M.B.Durh., F.R.C.S.Eng., Honorary Ophthalmic Surgeon to the Western General Dispensary, Marylebone Boad, N.W.

HILL, Miss E. S., M.B., Ch.B. Glasg., Medical Inspectress of School Children for the Borough of Burslem.

LLOTD, D. G., M.B.C.S., L.R.C.F.Lond., Certifying Surgeon under the Factory and Workshop Act for the Newcastle Emlyn No. 2 District of the counties of Carmarthen and Pembroke.

PATERSON, A. S., M.B., Ch.B. Edin., Resident Surgical Officer at the Royal Hospital, Salford.

REESE, DAVID WILLIAM, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of Health for the Warmley (Gloucestershire). Union.

REID DOUGLAS ARTHUR, M.D.Edin., M.R.C.S., L.S.A., Medical Officer of Health of the Borough of Tenby.
SUTHERLAND, HALLIDAY, M.D.Edin., Resident Physician to the Royal Victoria Hospital for Consumption, Edinburgh.
WALKER, E. A., M.B., Ch.B.Edin., House Physician at the Royal Hospital, Salford.

# Bacancies.

Birkenhead Union.-Resident Assistant Medical Officer. Salary,

Eirkenhead Union.—Resident Assistant Medical Officer. Salary, £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poorlaw Offices, Conway Street, Birkenhead.

Inverness District Asylum.—Junior Assistant Physician. Salary, £100 per annum, with board, lodging, and laundry. Applications to the Medical Superintendent.

Leeds Public Dispensary.—Junior Resident Medical Officer. Salary, £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary, North Street, Leeds.

The Royal National Hospital for Consumption, Ventor.—Male Assistant Resident Medical Officer. Salary, £100 per annum, with board and lodging in the Hospital, and washing allowance. Applications to the Secretary, 18 Buckingham Street, Strand, London.

Lavesden Asylum.—Third Assistant Medical Officer. Salary, £100 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Leavesden Asylum, King's Langley, R.S.O., Herts.

City Hospital, Birmingham.—Resident Assistant Medical Officer. Salary, £120 per annum, with board, washing, etc. Applications to the Medical Superintendent, City Hospital, Little Bromwich, Birmingham.

Beckett Hospital, Barnsley.—House Surgeon. Salary, £100 per annum, with board and lodging. Applications to R. F. Pawsey, Hon. Secretary, Barnsley.

The Hartlepools Hospital.—House Surgeon. Salary, £100 per annum, with board washing, and lodging in the Institution. Applications to Robert Edger, Secretary, 15 Town Wall, Hartlepool

Applications to Model's August, Hartlepool.
Worcester General Infirmary.—House Physician. Salary, £100 per annum, with board, residence, and washing. Applications to William Stallard, Secretary, Worcester Chambers, Pierpoint

# Births.

GIBBS-SHITE.—On March 22nd, at Cromer House, Teddington, to Edward G, Gibbs-Smith, L.R.C.P., D.P.H., and Ethei Harvard, his wife—a son.

Harvard, his wife—a son.

Harvar,—On March 24th, at Clarence Villa, Hartfield Road, Wimbledon, the wife of Joseph Harvey, M.B., of a son.

PALIN.—On March 25th, at The Oaks, Fakenham, Norfolk, the wife of Edward W, Palin, M.A., M.B., of a daughter.

Spitta.—On March 25th, at Wimbledon, the wife of Harold Spitta, M.D., of a son.

# Marriages.

THORNTON—DUNCAY.—On March 27th, in Edinburgh Dr. P. J. Thornton, of Bacup, Lance, to Winifred, second daughter of the late Thomas Duncan, of Edinburgh.

# Beaths.

PLAILIE-SHITE.—On March 24th, at Villa Victoria, San Remo, Patrick Blaikie-Smith, M.D., late of Aberdeen.

Coller.—On March 29th, at Ashurst Lodge, Worthing, Augustus Henry Collet, M.R.C.S., in his 65th year.

GERVIS.—On March 24th, from pneumonia, Frederick Harcourt Gervis, M.D., M.R.C.S., L.R.C.P., Surgeon-Captain 19th County of London Battelion, of 1, Lyncroft Mansions, West Hampstead, aged 37.

MESQUITA.—On March 28th, at the Whife House, Northdown Avenue, Margate, S. Buena de Mesquita, M.D., B.S.Lond., M.R.C.S., L.R.C.P., in his 47th year.

WALSH.—On March 25th, at the New Hospital for Women, Euston Road, London, of pneumonia, Anna Belinda Walsh, M.B., B.S.Lond., junior assistant resident surgesn, younger daughter of Rev. Canon Walsh, D.D., St, Mary's Rectory, Donnybrock, Dublin.

Have you noticed that an injection or instillation of

# ARGYROL

(SILVER VITELLIN)

relieves the pain of local inflammation, while all other silver salts increase the pain? Moreover, scientific studies prove that Argyrol quickly destroys gonococci.

These facts explain why Argyrol is considered, the world over, a superior remedy in the treatment of gonorrhœa (injection of 10 per cent. solution every three hours) and other inflammations of the eye, throat, nose and ear (25 per cent. solution instillation or local application).

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The following statement concerning

# OVOFERRIN

(IRON VITELLIN)

is a copy from the official records of the largest clinic in Germany where the remedy has been in continuous use for more than four years:

"Ovoferrin is an easily assimilable, well tolerated remedy which does not disturb digestion or cause constipation, but improves the appetite, digestion and general nutrition, and produces steady and progressive increase in the percentage of hæmoglobin and red corpuscles."

Ovoferrin is furnished by chemists, on prescription, in twelve ounce bottles. The dosage is one tablespoonful in a wine-glass of water or milk three times daily.

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# **PNEUMONIA**

In PNEUMONIA the inspired air should be rich in oxygen and comparatively cool, while the surface of the body, especially the thorax, should be kept warm, lest, becoming chilled, the action of the phagocytes in their battle with the pneumococci be inhibited.

# Antiphlogistine

(Inflammation's Antidote)

applied to the chest wall, front, sides and back, hot and thick stimulates the action of the phagocytes and often turns the scale in favour of recovery.

It is an acknowleged fact, as declared by a well-known medical teacher and author in his latest text-book on treatment, that "heat applied and persisted in over the entire diseased area is a most potent and physiological antagonist to those essential conditions which are directly induced by the causes of the disease, and from which all ultimate pathologic results must develop. It is profoundly stimulating, and while local heat from undue combustion is present, the applied heat stimulates the capillaries and physiologically unloads the venous capillaries. At the same time it stimulates the arterial capillaries through its influence upon the peripheries of the nerves, and secondly upon the nerve centres, to drive the accumulating tide through the engorged vessels, thus unloading them into the veins. It thus carries off the accumulating waste, brings into the capillaries a new tissue supply, and quickly remedies the harm that has been done them in the primary congestion.

"It is a most rational procedure. It is logical, it is reasonable, it is physiological and it is highly scientific. And such a course is always acceptable."

# **CROUP**

Instead of depending on an emetic tor quick action in croup, the physician will do well to apply Antiphlogistine hot and thick from ear to ear and down over the interclavicular space. The results of such treatment are usually prompt and gratifying.

Antiphlogistine hot and thick is also indicated in Bronchitis and Pleurisy

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Is instantly and wholly assimilable and sterile.

# **PANOPEPTON**

Contains all the extractives, salts, and savory matters of the beef juice, which are of peculiar value as stimulants.

# **PANOPEPTON**

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# **PANOPEPTON**

Is a complete food, containing the albuminoids, carbohydrates and phosphates—the flesh, fit, and bone making elements.

For an adult the usual portion should be a dessertspoonful to a tablespoonful several times a day and at bedtime.

Supplied to the Medical Profession in 6 oz. and 12 oz. bottles, at 2/2 and 3/8 each.

Specimen and Pamphlet will be forwarded on request.

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# HOMMEL'S Hæmatogen

CONTAINS NEITHER ALCOHOL NOR ANTISEPTICS

A combination of 80 parts purified and concentrated Hæmoglobin with 20 parts chemically pure Glycerine and Aromatic Flavouring.

The best of all the existing preparations of Hæmoglobin. More efficacious than Cod-Liver Oil or the ordinary manufactured preparations of Iron. Very strengthening both for Children and Adults. An energetic Blood Former. Increases the Appetite. Aids Digestion.

- Extremely useful in Rickets, Scrofula, General Debility, Anæmia, Weak Heart, Neurasthenia, and Convalescence from illness such as Pneumonia or Influenza.
- Unsurpassed as a Strengthening Restorative in Diseases of the Lunge. Has a very agreeable taste, and is taken with the utmost relish even by Children.

FREE FROM BACTERIAL GROWTH.

These important qualities are guaranteed by using the highest permissible temperature in the process of manufacture (130° to 140° Fahr. for 24 hours). No guarantee of this description is possible for preparations made by a cold process with ether.

In prescribing, always state "HOMMEL'S" Hæmatogen as spurious imitations are offered.

ONLY SUPPLIED IN FLUID, NOT IN CAPSULES OR OTHER FORMS.

Infants - Take from Half to One Teaspoonful twice a day in milk.

Children - One or Two Dessertspoonfuls daily, either pure or mixed with any convenient liquid,

One Tablespoonful twice a day before the two principal meals.

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ects."
Children."
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of SCOTT'S EMULSION. I have recommended it to hundreds of delicate children with wonderful effects, and in proof of my appreciation of it have frequently administered it to my own little ones.
Yours very truly, ————————————————————————————————————

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# There is only one Adrenalin

# —the constringent, cardiac-stimulant and bloodpressure-raising principle of the suprarenal gland.

In January, 1901, PARKE, DAVIS & CO. introduced ADRENALIN into medicine. This principle was isolated in 1900 by Dr. TAKAMINE, a member of their scientific staff, and the sole right of manufacture by his process is vested in them.

The remarkable clinical results which established the position of the suprarenal principle in medicine and surgery, were obtained by the use of Adrenalin. The great importance of this therapeutic agent has brought into the market numerous preparations offered as substitutes. The action of some of these is unreliable (see article in The Proceedings of the Royal Society of Edinburgh, 1905-6), and a writer in the British Medical Journal (1908, I., 1565) states:—"Adrenalin is undoubtedly the best form of this substance."

## PREPARATIONS.

#### Adrenalin Chloride Solution, 1:1000.

**Adrenalin Tablets** (one dissolved in 1 c.c. [16.9 minims] of sterile distilled water forms the 1:1000 solution).

Adrenalin Solution has proved invaluable in numberless conditions, e.g., hæmorrhages of every kind where it can be brought into contact with the bleeding orifices, inflammations of mucous membrane, ocular hyperæmia, keratitis, iritis, lachrymal obstruction, etc.

Intravenously, in cardiac and respiratory failure it stimulates the heart almost instantaneously. Injected into serous cavities it checks effusions; into the bladder, urethra, or vagina it subdues congestion and arrests hæmorrhage.

It is given in hæmophilia, purpura, etc.; also to arrest vomiting in chloroform anæsthesia, and to obviate syncope.

## Adrenalin Suppositories.

1:1000. Used in rectitis, hæmorrhoids, rectal hæmorrhage, anal fissure, etc.

#### Adrenalin Inhalant.

A 1:1000 solution in aromatised neutral oil containing 3% of Chloretone (antiseptic and sedative). Most effective as a spray in laryngitis, whooping cough, rhinitis, hay fever, bronchitis, asthma, and in subacute and chronic inflammations of the nose, throat, and bronchi.

#### Adrenalin Ointment.

1:1000. Ensures more prolonged local action than either the Solution or the Inhalant in coryza, rhinitis, hay fever, inflammations of the urethra, vagina, cervix uteri, etc. Often of service in eczema, anal and vulval pruritus, etc.

## Adrenalin and Chloretone Ointment.

1000 parts contain 1 part of Adrenalin and 50 parts of Chloretone whose analgesic properties are valuable in inflammatory conditions of mucous membrane accompanied by pain or irritation.

By retarding diffusion Adrenalin enhances the local effect of cocaine or eucaine, whilst it diminishes their toxicity. As means for performing "painless and bloodless" surgery and dentistry, the following "P., D. & Co." preparations have been universally approved.

"Codrenine," "A" and "B."—Respectively 2 per cent. and 1 per cent. of cocaine hydrochloride with Adrenalin chloride (1 in 15000 and 1 in 5000) in physiological sodium chloride solution preserved with Chloretone.

Adrenalin and Cocaine Tablets, "A" and "C"
(P., D. & Co.).—Respectively containing 1-300 and 1-400 grain
of Adrenalin with 1-6 and 1-3 grain of cocaine hydrochloride.

"Eudrenine."—A 1 per cent. solution of beta-eucaine hydrochloride with Adrenalin chloride (about 1 in 30000) in physiological sodium chloride solution preserved with

Adrenalin and Eucaine Tablets (P., D. & Co.).— Each contains 1-2000 grain of Adrenalin, 1-8 grain of eucaine lactate and 3-5 grain of sodium chloride.

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Diseases of the Mucous Membrane, especially in their chronic forms, together with the sequelæ of Catarrhal Influenza, Pneumonia and Pleurisy, Hyper-acidity of the Stomach, Catarrh of the Intestines, Bladder and Uterus, and many female complaints are amenable to

# NATURAL TREATMENT

by EMS WATER, which, however, should always be given under Medical advice, its use being contra-indicated in acute diseases and febrile conditions.



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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, APRIL 7, 1909.

No. 14.

# Notes and Comments.

A LEGAL action for damages recently brought against the mayor, com-The Responsibilities monalty and citizens of London, as of Hospitals. governors of a London hospital, opens up issues of vital importance to the medical charities of the United Kingdom. The plaintiff, a medical man, suffered from a nervous disorder, for the relief of which a surgical operation was advised. He was accordingly admitted to the wards of the hospital in question, where he underwent operation. Unfortunately during that proceeding his arms came into contact with the heating apparatus of the operating table and he was severely injured. Later, he brought an action against the hospital authorities for damages on account of the permanent injury he had sustained. The foregoing facts do not appear to have been disputed, but the defendants denied responsibility, on a ground that was upheld by Mr. Justice Grantham, who is reported to have said that, were such an action sustained it would be practically impossible to carry on the work of the medical charities. With all due deference to the judicial view, we venture to think that there are certain responsibilities connected with the discharge of public duties by hospital governors, whether assumed in the cause of charity or otherwise. The failure of treatment to effect relief or cure is a matter for which a hospital cannot be answerable, but we imagine that the mere reception of a patient implies that the governors are responsible for reasonable skill and care in the carrying out of all treatment that may be required.

Is Mr. Justice Grantham be right,

Is Mr. Justice it follows, of course, that no hospital

Grantham can be sued for damages for acci
Right? dent injury. At the hearing of the

trial he stopped the case with
the declaration, "I hold there is no case to go to
the jury. It would be a policy fatal to the good
of the country, and the injury done would be untold
if I allowed this case to go to the jury." It may
be that he was referring merely to the view that
the action, if any, should have been brought
against the surgeons, and not against the
hospital authorities. It would have been
more safisfactory, however, in many ways,
had a reasoned judgment been delivered
upon what seems to be a point of considerable importance to the safety of the large
number of our fellow countrymen who resort to
hospitals for treatment. We should imagine there
is a very great deal to be said upon the conditions
of the contract implied in the reception of patients
into the wards of a hospital. Now that the
principle of compensation for accidents is being so

universally applied, it is not easy to see why a man should have no ground for compensation for damage sustained under the circumstances that led to the claim. This particular hospital management is above suspicion, and the occurrence obviously falls within the category of pure accident. Should the case go to appeal, its legal aspects would probably secure more detailed consideration than the fortune of war has accorded them in the present trial.

Black List Patients. AT a recent meeting of the Cardiff Guardians a letter was read by one of the district medical officers which has attracted a good deal of interest and comment. This gentleman, Dr. T. F. Roche, brought to the notice

of the Board the increase in the number of the persons applying to him for parochial medical attendance. This increase, he said, was due, to some extent, at any rate, to a plan which had been adopted by some of the younger practitioners at Penarth of keeping a black list of those patients who did not pay for their medical attendance. It seems that when a patient on the list applies to a practitioner for attendance, he asks for cash down, and if that is not forthcoming the medical man declines to attend. It is said that already there are some 600 or 700 black-listed families. We confess that we are very glad to see the medical profession taking this eminently judicious and sensible method of dealing with systematic "bilkers," as it is the only one likely to be effectual, and it should be adopted by men in all districts. At the moment the results, as far as Dr. Roche is concerned, are very unfortunate, as the rejected ones all come to him, and if he makes any difficulty they go to the relieving officer and get an order for free attendance. Consequently he finds himself much burdened with work.

Our sympathies are with Dr.

Roche, and now that his complaint has been brought forward and referred to a committee, we look to see the guardians revise their method of medical relief. The black-listed people, in many cases at any rate, are well able to pay, and now that they find they can so easily obtain free medical attendance, the work falling on Dr. Roche's shoulders is very considerable. Something is evidently bad about a system under which abuse of this type can spring up, and that it should exist is an admirable example of the argument contained in Dr. McVail's report to the Royal Commission on the Poor-law, referred to in our leading article this week. If free relief is granted to the poor, it

should be the relieving officer's business to find out if the applicant is deserving and really poverty-stricken, and if not the cost should be recovered by the former on behalf of the guardians, who should hand the fees thus obtained to their medical officer. The same principle is recognised in the case of emergency medical attendance on women attended by midwives, and also in the feeding of school-children whose parents are found to be able to pay. Its adoption seems to us the right way out of such a position as that at Penarth.

It is with great regret that we learn of the tragic death of Dr. A. B. Medical Wilson, house physician to the London Hospital. In the course of Martyr. his duties last month he had to attend to a woman who had taken poison with suicidal intent, and in inserting a gag to facilitate the passage of the stomach-pump, he was bitten on the thumb, the woman struggling violently in her determination not to have her purpose foiled. The wound apparently was a comparatively slight one and soon healed, but shortly afterwards he fell ill and was discovered to be suffering from blood-poisoning, with high temperature. In spite of every care and attention he died within a week. As the coroner who held an inquest on him, remarked, his was "another life sacrificed in the interests of other people. There is no doubt that there is a great deal of generous conduct and selfsacrifice on the part of doctors." It is pleasant indeed to hear a tribute such as this borne by a layman to the unseen and unappreciated daily labours of medical men, whose risks and devotion to duty under many dangerous circumstances are so little heeded by the public. Of a truth, over the grave of this promising young colleague it may be written, "He died for others."

Doctors
and
Motoring.

THE Kingston County Bench has a name which is held in awe by a certain section of motorists, and we ourselves are fully in sympathy with the magistrates in their determina-

tion not to let their roads be made a source of terror to residents because of the thoughtless conduct of inconsiderate scorchers. Last week they still further vindicated their good sense. Mr. Stansfield Collier, who was down in Surrey, was telephoned for by his house-surgeon at St. Mary's to see a patient who was in a critical condition, and Mr. Collier motored up with all speed, telling the chauffeur to drive as quickly as possible, with due regard to safety. At Cobham he was stopped by a policeman on the Portsmouth Road and told that he was travelling twenty-nine miles an hour. Mr. Collier explained that he was proceeding to an urgent case, but was nevertheless served with a summons. The circumstances were explained to the Bench by Mr. Collier himself, who added that had he not been stopped and hindered by the policeman he believed he could have saved the patient's life. Under the circumstances the magistrates decided that it would be inexpedient to impose a fine, though they thought the police were right in bringing the case forward. We admit it is difficult to abrogate the law in favour of medical men, and we are glad the case was dismissed, but bringing such a case at a distance from London and putting a defendant to all the cost and loss of time is in itself no light penalty.

# LEADING ARTICLES.

POOR-LAW MEDICAL RELIEF.

FOLLOWING on the heels of the majority and minority Reports of the Royal Commission on the Poor-laws, there appeared last week a thoughtful report by Dr. John C. McVail, County Medical Officer for Stirlingshire and Dumbartonshire, who had been deputed by the Commission to inquire into the methods and results of the present system of administering indoor and outdoor medical relief in certain selected unions. The investigations were confined to England and Wales and took count of both rural and urban districts. In nine parts, the Report treats every side of the subject, such asinfirmaries, rural and urban, workhouses, outdoor medical relief, the popularity and unpopularity of Poor-law medical aid, and the supervision of children, together with references to provident institutions for supplying medical aid and medical inspection in the home. Very pertinently, Dr. McVail points out that Poor-law medical relief is a hiatus between public charity, as evidenced by the general hospitals, and private charity supplied by medical practitioners, and that were there not these twoprops the whole system would break down. question of medical relief for the poor is, in fact, in a state of chaos; there is no co-ordination and nosystem. Private charity, the willingness of medical men to do what they can for the sake of humanity, and the support of public hospitals-all these factors vary in different districts, and the Poor-law is the padding which fills up the gaps. We are glad indeed that this unhappy, unfair, and galling muddle is so clearly set forth in a document of this importance, and we hope that once the fact is admitted, legislators and social reformers will not rest till the scandal is removed. Another point of great importance made by Dr. McVail is that if the State, as represented by the Poor-law authority, confers benefits on individuals, it has a right to demand in return a degree of submission to its orders and requirements. The hopeless condition into which our present Poor-law system has sunk is due to the disregard of the elementary principle of the quid pro quo. The State should be willing to provide for the poor and needy, but it should enforce on its protégés reasonable conditions of discipline, with the object of preventing their becoming frequent or permanent burdens on its shoulders. In a free country it may be difficult to prevent a man with money in his pocket from getting drunk, but when his money is gone and he is the subject of delirium tremens he is taken to the infirmary. Is he to be allowed out immediately he has recovered to indulge till he again comes back with the same complaint? And is he to be allowed indefinitely to pursue the same cycle of folly and disease? Again, in the case of weak-minded girls, who resort to maternity wards whenever, through pregnancy, they are unable to follow a life of immorality, are they and their babies to become a charge on the State without that institution taking any steps to guard them from a recurrence of their vice? The infirmaries have always their quota of diseased prostitutes who are no sooner nursed through the acute stages of their trouble than they are released at their own demand to pursue their

career, speading far and wide their foul disorders. Is this to the advantage of the community, and has the State no right of interference? So much for indoor treatment of this side of the relief of the sick poor. We turn to the outdoor. Says Dr. McVail of outdoor medical attendance: It is "freely and unconditionally provided by the guardians for the drunken and immoral." While these conditions prevail, in his opinion, it is not worth while entering on any reform of the Poor-law. We need hardly say that, in the main, we are in agreement with Dr. McVail. If reform is worth undertaking (and who can doubt that it is?), the reform should be radical and complete. It is easy enough to tinker by treating symptoms; what is needed is control of the causes. A person who, through his own fault, through mental or moral disease, or through vice, becomes a charge on the State, whether represented by the present guardians or, as we all hope, by a new and more dignified body, should have treatment; but that treatment should not be merely temporary and directed to the alleviation of his immediate necessities, but of such a character that the chance of his returning to his old vicious mode of life is rendered as improbable as human effort can make it. Such a condition requires that the Poor-law authority should have strong disciplinary powers, including the right to punish and the right to detain, and, further, and perhaps more important, the duty of, and machinery for, following up delinquents and exercising a guiding and controlling influence on them. The laxity of our present system permits, nay, puts a premium on, waste, dissoluteness, and irresponsibility, and thereby stands self-condemned. This fact has been borne in upon all right-minded people who have given attention to the subject, and must be impressed upon the community generally. We wish we had space to go on to the many other interesting matters in Dr. McVail's suggestive report.

## MOTOR DUST AND MILK.

A SANITARY inspector has recently called attention to the injurious effect motor dust has upon milk, and has urged upon dairymen and milk purveyors the necessity of protecting milk from that source of contamination. While the thanks of the public are due to Mr. Henry Johnson, the gentleman in question, for his timely warning, it seems desirable, nevertheless, that some qualification should be added to his proposition. First and foremost, much depends on whether the dust raised by the motors is that of town or of country roads. In the urban areas there is a vast deal of organic matter and of pathogenic material which it is most undesirable should reach so favourable a culture medium as that afforded by milk. In rural districts, on the other hand, the proportion of organic contamination of road dust is small. Nor, again, does the dust raised by motors differ in its composition from that due to horse traffic, except as regards amount and the lessened contamination by horse-droppings, owing to the displacement of the old nidus for traction by mechanical power. In point of fact, then, the problem of motor dust and milk is much the same as that hitherto presented by ordinary dust in relation to milk, and from that point every sanitarian will readily endorse Mr. Johnson's views.

Anything that educates the community upon the relation of an important foodstuff to the public health is deserving of the utmost encouragement. Hitherto the task of bringing milk under efficient sanitary control has been curiously slow. now more than half a century since such diseases as scarlet fever and enteric fever were definitely traced to the agency of contaminated milk. Since then various specific infective maladies have been added to the list, that of tuberculosis being the latest and the most important. In spite of the comparatively long period that has elapsed since the recognition of these special dangers in relation to milk, an effective sanitary control of that article of food cannot yet be said to be in existence. Even within the last few years epidemics of milk-typhoid have been reported from various parts of the Kingdom. Indeed, were it not for the saving clause whereby the consumer can shield himself to a great extent, if not absolutely, by boiling his milk. the evils arising in connection with that article would be simply rampant. Yet there is much matter for congratulation, even in the midst of our confession of shortcomings. At the present moment the great advance is being made of bringing producer and distributor under a system of combined urban and sanitary control. Another important step has been taken in inducing rural sanitary authorities to inspect the dairy cattle in their districts. When Parliament adds the keystone of compulsory slaughter of tuberculous cattle, with compensation to owners, the great end of the extermination of human tuberculosis in the United Kingdom may be regarded as well within sight. Meanwhile, there yet remains a great deal to be done in the scientific control of town distribution. Mr. Johnson has called attention to one of the main principles in that direction, namely, the exclusion of dust, whether of vehicular or other origin. The time is ripe for dealing with this and kindred points in the light of practical sanitary knowledge, and it is to be hoped that both our central and our local sanitary authorities will before long draw up authoritative by-laws for the regulation of the conditions under which an important foodstuff is stored and distributed by the retailer.

# CURRENT TOPICS.

# A Modest Savant.

In the present days of inflated reputations and of scientific advertisement it is refreshing to hear of a modest village practitioner who, without a hospital service or laboratory, had, fourteen years ago, done work that practically compelled the members of that most exclusive of all learned societies, the Paris Academy of Medicine, to choose him as one of their number. Few contemporary writers have contributed more copiously to the literature of their profession than Dr. Liégeois, of Bainville-aux-Saules (Vosges), nor have dealt with so many difficult questions with such constant distinction. Dr. Liégeois has earned for himself no less than nineteen times the title of laureat of universities and of learned societies for memoirs submitted by him in open competitions. Amongst these may be mentioned the Bernard de Civrieux prize in 1880, on the "Rôle of the Nervous System in Diseases of the Heart."

In the following year the Faculty of Paris selected as the best his monograph on "Measles." Two years later he gained six prizes, amongst them the Prix Montyon of the Paris Faculty, and a first mention at the Académie des Sciences for a memoir of 1,700 pages on the "Neuropathology of the Heart and Respiratory Apparatus." In 1884 a memoir on the "Ætiology, Pathology and Surgical Treatment of Gangrene of the Limbs," of 500 pages, was awarded the Prix Gerdy of the Society of Surgery, and this was followed up by the Prix Montyon for the second time, "On Influenza and Whooping-Cough." In 1885 he competed for the Grand Prix Portal of the Academy of Medicine, with a memoir on "The Causes and Nature of Angina Pectoris," m which he suggested what was then an entirely original theory of the mechanism of this affectionviz., that of anæmia caused by persisting ischæmia, and determined by visceral troubles, emotions, movements or efforts. The Academy endorsed the views of the author by giving him the prize, which he again obtained the following year with an essay on "Exophthalmic Goître." Besides his prize essays Dr. Liégeois has published innumerable memoirs, monographs, volumes, and articles upon the most varied subjects, although he has always shown a certain predilection for the pathology of the heart. Notwithstanding his scientific activity, Dr. Liégeois still finds time to perform the duties of mayor of his village, of cantonal delegate, of inspector of schools and of infants, of member of the Council of Hygiene, and also to manage the charities in his district. The picture of his extraordinarily full and distinguished career is particularly inspiring to those who are called upon to labour in the obscurer paths of a varied profession like that of medicine.

# Explosive Hair-Washes.

THE use of highly inflammable or explosive ingredients in hair-washes has practically fallen into disuse in the United Kingdom. In case of accident any person responsible for such a preparation would probably have to pay a heavy penalty as the result of a civil or a criminal action. Not many years ago the tragedy of lives sacrificed to the explosive hair-wash was of comparatively frequent occurrence, for it so happens that paraffin, ether, and other substances that give off highly inflammable vapours are extremely efficient in cleansing the hair and scalp. In France a well-known actress was recently burned to death in consequence of the explosion of a lotion containing ether with which a hairdresser was washing her head. Many valuable hair lotions, needless to say, are made without the use of these dangerous volatile substances. Spirits of wine, largely used in these preparations, are comparatively safe, although the person who uses them should always be warned against approaching a lighted candle or other naked light. In spite of former disastrous experiences, however, the use of petrol for cleansing the scalp has crept in to a limited extent, although its ultimate effect on the hair is destructive.

# The Children's Charter.

THE Children's Act, 1908, which came into operation last week, deserves the nickname it has received

in the evening press-the Children's Charter-on account of its very comprehensive character. In many respects, indeed, the charter imposes restrictions rather than grants privileges, but the restrictions are for the most part wise and in the child's interests. Some will think the prohibition of tobacco-smoking by all persons under sixteen a little grandmotherly, and we must confess we do not think it necessary to give to constables and park-constables the power of searching boys for suspected tobacco. Some of the most important clauses of the Act deal with the inspection of and protection of children at nurse. Among other things, it is forbidden for those who nurse children for reward to effect policies of insurance on their lives, and it is rendered penal for insurance companies to issue such policies. "Overlying" of children, if the person in bed with the child has gone to bed under the influence of drink, is rendered an indictable offence, punishable by a fine of £100, or imprisonment for two years. The giving of alcoholic drink to a child under five years of age is prohibited under penalty, except upon the order of a medical man or in case of illness. Other important sections deal with reformatories, juvenile offenders, and begging, but the points treated are too many to be enumerated here.

# Representation of Professional Interests in Parliament.

WE have often had to deplore the fact that the interests of medical men go unrepresented in Parliament, and, as a result, that legislation frequently trenches on their rights. For years the suggestion has been before the medical profession that certain members should be returned in the medical interest, whose chief duty should be to represent the views of the profession in all matters affecting either the health of the community or the interests of medical men. Nothing has so far been done to bring the suggestion into effect. We learn, however, that the members of the pharmaceutical craft are ahead of us, and, a candidate having been found, the President of the Pharmaceutical Society is appealing for support for his candidature. Pharmacists who desire a direct representative in Parliament are requested to subscribe to a guarantee to cover Mr. Glyn-Jones' election expenses, and this irrespective of party questions. It is said that Mr. Glyn-Jones, the selected candidate, will be given a constituency to fight in the Liberal interest, and pharmacy is to pay his election expenses and concentrate its influence towards his return. The experiment will be watched with great interest by medical men.

# The New Poisons Act.

The new Poisons and Pharmacy Act, which came into operation at the beginning of the present month, has various features of medico-legal interest. While it provides greater safeguards for the sale of poisons used for medical purposes, it extends the facilities for obtaining poisonous compounds used in horticulture and agriculture. Hitherto none but chemists have been allowed to sell sheep dips, weed killers, and other preparations containing arsenic and nicotine, but under the new Act county, town and borough councils may license ironmongers,

florists and others to sell such preparations in districts where the demand is not properly met. The licence is obtained in the first instance at a fee of not more than 21s., and is afterwards maintained by an annual payment of 2s. 6d. Oil and colour dealers are now required, under a penalty of £5, to label any vitriol, spirits of salt and nitric acid which they sell with the word "Poisonous," and to place on the labels their names and addresses. The list of poisons used in medicine which may be sold only by a qualified chemist is extended under the new Act, and opium has been placed in a special list of poisons, which includes morphia, cocaine, belladonna and prussic acid, which may be sold only to a person whom the chemist knows, and the purchaser is required to sign his name in the poison book, and at the same time to state the purpose for which the drug is required. In future the word "chemist" will be superseded by the word "pharmacist," and the latter title will be reserved solely for qualified individuals. In all shops where the business of chemist and druggist is carried on the qualified person in charge must display his certificate showing he is on the official roll of chemists in a conspicuous position.

## National Health in Ireland.

HER EXCELLENCY LADY ABERDEEN, who is always looking for fresh fields of disease to conquer in Ireland, delivered a very important address under the auspices of the Dublin Education Society during the past week on matters relative to the health of the growing child. In the course of the address, Her Excellency formulated a scheme for the formation of a boys' and girls' National Health Battalion, which had already gained the approval of the Commissioners of National Education. The "company card" which each boy or girl signs on joining, though perhaps containing too many different promises, still is most admirable—if only it could be carried out. However, a high ideal is always wise. The promises made by each member of the battalion are practically summed up in the first clause of the "card": "To try to practice personally the lessons on the laws of health which I receive at school," and the remaining clauses deal specifically with the items included in such a promise. There are some which, we fear, will be anathema to the members of the battalion, but there are others which might indeed be regarded, not as duties, but as rewards, for instance, "to look out for rats and kill them." If anything will compensate the average peasant boy for having to wash his teeth it will certainly be the privilege of kill-ing rats at sight! There is one curious difference between the "cards" drawn up for the boys and girls respectively. A boy is required "to wash himself daily with soap and water, to clean his teeth night and morning," whereas the girl is only told to clean her teeth night and morning, and there is no mention of washing. As medical men we must protest against the idea that a girl requires less washing than a boy. Physiologically she probably requires more, and certainly after puberty she requires more urgently the habit of washing. Further, amongst the poorer class in Ireland the boy is sometimes washed in summer, as he usually bathes whenever he gets the chance, whereas the girl seldom or never does. We therefore suggest that, in this most important particular, the rules for the girl should be altered.

# PERSONAL.

THE MEDICAL PRESS. 345

HER MAJESTY THE QUEEN, accompanied by the Empress Marie Feodorovna, paid a prolonged visit to the London Hospital on Tuesday last.

THE Prince and Princess of Wales, Prince and Princess Christian of Schleswig-Holstein, and other Royalties have given their patronage to the annual festival ball in aid of the Italian Hospital on May 10th.

PRINCESS ALEXANDER OF TECK will open the new Out-patient Department and Nuises' Home of the Royal National Orthopædic Hospital on Tuesday, April 20th. The treasurers, Lord Farquhar and Sir Richard Martin, have received a donation of £500 from the Goldsmiths' Company towards the reduction of the hilding debt of Characteristics. of the building debt of £25,000.

The Duke of Argyll will preside at the 64th anniversary clinner of the German Hospital, Dalston, which will be held at the Whitehall Rooms on Friday, May -th.

On March 24th the Prince of Wales received Sir William Church, Chairman of the Executive Committee, and Dr. E. F. Bashford, Director of the Imperial Cancer Research Fund, and considered the affairs and progress of the fund, of which he is President.

Last Monday was the 82nd birthday of Lord Lister, O.M., F.R.S., Sergeant-Surgeon in Ordinary to the King, his lordship having been born at Upton on April 5th, 1827.

Dr. Meredith Young has been appointed Medical Officer of Health for the county of Cheshire, in succession to Dr. Vacher (resigned). Dr. Young was Medical Officer for the metropolitan borough of St. Marylebone.

A FESTIVAL dinner in aid of the funds of the East London Hospital for Children, Shadwell, E., will be held at the Ritz Hotel on Wednesday. April 28th. Field-Marshal Lord Grenfell will preside.

The Gilchrist Studentship for Women has been awarded by the Senate of University of London to Miss Enid Margaret Walters. M.B., B.S. The Studentship is of £100, for one year, and is open to graduates in Honours of the London University.

In aid of the Queen Alexandia Sanatorium at Davos a matinée will be given on Tuesday, May 11th, at Drury Lane Theatre. Mr. Arthur Collins has lent the theatre, and many well-known dramatic and variety artistes have offered their services.

THE late Rev. Walter Howse, M.A., of King's College, London, has left the residue of his property to Guy's Hospital, London, in augmentat on of its endowment. It is estimated that the bequest to Guy's Hospital will amount to about £25,000.

We are glad to learn that Dr. Squire Sprigge, who has been chief of the editorial staff of our contemporary, the Lancet, has been formally appointed editor of that journal, and we beg to offer him our congratulations on his well-earned promotion.

In the Board-room of the Westminster Hospital on April 1st a presentation was made to Sir William Allchin, Vice-President and Consulting Physician to the hospital. The presentation took the form of Sir William's portrait in oils, painted by Sir Luke Fildes, R.A. All the medical staff of the hospital and many of the past students have contributed. Sir John of the past students have contributed. Sir John Wolfe Barry, Chairman of the House Committee, who presided, mentioned that Sir William was connected with the Westminster Hospital as medical registrar in 1871, assistant physician in 1874, physician in 1877, and consulting physician and vice-president in 1905.

# A CLINICAL LECTURE

ON

# DUODENAL ULCER: ITS DIAGNOSIS AND SURGICAL TREATMENT. (a)

By JAMES SHERREN, F.R.C.S.

Assistant Surgeon to the London Hospital, Surgeon to the Poplar Hospital for Accidents.

I HAVE recently had under my care several cases of ulcer of the duodenum presenting symptoms so puzzling that a definite diagnosis was impossible before operation. This led me to review the notes of all the cases of duodenal ulcer which have been under my care, in which the diagnosis was established by operation, and also all the cases of gastric ulcer diagnosed in the same way, to see if the impression I had formed was the correct one—that although a definite diagnosis is possible in most cases, in some an accurate diagnosis cannot be made. I have only used for this purpose those cases in which the ulcer of the stomach or duodenum could be demonstrated even to an onlooker, cases in which the ulcer had led to signs, both visible and palpable.

The surgery of duodenal ulcer is of recent date. We

owe much of our knowledge to the work of Mayo Robson, Moynihan, and the Mayos.

Considerable difference of opinion has existed, and still exists, with regard to the possibility of diagnosing the exact location of a peptic ulcer-whether in the stomach or the duodenum.

In the second edition of "Osler's Medicine" (1895) the following occurs:—"Can the gastric and duodenal ulcer be distinguished clinically?.... In the vast majority of cases they cannot be separated during life as the symptoms produced are identical."

Twelve years later Moynihan writes: "The symptoms of duodenal ulcer are, in the great majority of cases, sufficient to enable a diagnosis to be made."

Again, the death-rate following operation for the perforation of a duodenal ulcer is, in my experience, much greater than that of perforating gastric ulcer. These reasons have led me to take up a subject about which so much has been written of late years, but in which great room for improvement exists in the early diagnosis and treatment of the cases, particularly

when perforation has occurred.

Duodenal ulcer was, only a few years ago, looked upon as a rare condition when compared with gastric ulcer. The reasons for this are plain: Firstly, the possibility of exact diagnosis which has resulted from the extension of surgical treatment in disease of the stomach and duodenum, cases which were formerly considered to be gastric ulcer, or acid dyspepsia, now falling into their right group. Secondly, the appreciation of the exact limit between the stomach and duodenum, as W. J. Mayo has pointed out, this is marked by two veins which pass one from the superior and one from the inferior margins of the pylorus and form an almost complete venous ring, marking the pyloric orifice. This landmark can be defined in the majority of cases. As 95 per cent. of all duodenal ulcers, according to the same authority, extend to within three-quarters of an inch of the pylorus, this exact localisation is necessary. It may be asked what is the importance of these facts. Deaver and Ashurst state: "This fine distinction between gastric and duodenal ulcers is of more theoretical than practical importance, since ulcers of the first part of the duodenum so closely resemble those of the stomach in their clinical pathology, symptomatology and indications for treatment that a differentiation is rarely important." With regard to much of this statement I am not in accord, by far the greater number of cases of duodenal ulcer have symptoms which differ entirely from those given by chronic gastric ulcer, and I hold with most surgeons that the indications for

treatment are not identical. To look upon the subject in this light is unwise. Every addition to our surgical knowledge is of value and exact diagnosis should. be made where possible.

W. J. Mayo found that 60 per cent. of peptic ulcers were situated in the duodenum, Robson has given the figures as 1 to 2, with these my figures agree, 24 duodenal, 47 gastric; Osler and McRae give a higher proportion, 1 to 1. All are agreed that the condition proportion, I to I. All are agreed that the condition is much more common in men than in women. The figures given by different authorities vary somewhat, thus Moynihan found it twice as often in men as in women; the Mayos, 73 per cent. of men; Mayor Robson, 86 per cent. males; Seymour Taylor, 72 per cent. males. In my 24 cases, 22 were males. The same difference is shown in the sex incidence of perforating gastric and duodenal ulcers. During the past ten years 174 cases of perforated peptic ulcer have been treated at the London Hospital, 132 gastric, 42 duodenal, of the former 88 were male, 44 female,

of the latter 38 were male.

Duodenal ulcer may be met with at any age, but is most common about 35—40, of my series of cases the youngest was 19, the oldest 56, but the condition has been recorded in infancy. Oppenheimer collected 15 cases in children in whom melæna was the chief symptom.

According to the symptoms, it is possible to divide duodenal ulcers into four groups.

- 1. Those in which the symptoms which bring the patient under medical care are due to perforation. In many, this is the very first symptom noticed.
- 2. Those in which a definite diagnosis may be made. 3. Those in which the diagnosis of a peptic ulcer of stomach or duodenum may be made, but the symptoms are not clear as to which it is.
- 4. Those in which the diagnosis is not possible until operation.
- r. Perforation of a duodenal ulcer is one of the most serious of those surgical diseases which are amenable to treatment if diagnosed and operated upon early. These cases are often tragic in their suddenness. A man in the prime of life is suddenly seized with acute abdominal symptoms; if, as is sometimes the case, these are considered due to "liver," or "biliousness," and are lightly looked upon, a fatal result is almost certain.

In many instances, nothing indicative of the presence of an ulcer can be elicited from the past history, in only four out of the eleven upon whom I operated could I obtain a history of past dyspepsia or abdominal trouble, and in none of these was it severe. One had had "an attack of pain after food and the severe of th vomiting, lasting a few days, a year ago, but had been quite well since; "another, a very alcoholic subject, had suffered from "indigestion for five or six months, with nomities of the property of the prope months, with vomiting after meals;" in yet another there had been "pain after food, but no vomiting, for three years;" in this case there was a chronic ulcer.

Judging from the appearance and feel of the ulcers,

as discovered at operation or examined after death, all except three were chronic, although only four of the eight had produced symptoms during life until perforation occurred, and in the cases in which symptoms were produced they were not severe enough to lead to medical aid being sought in three cases; had they, it is quite probable that a diagnosis could have been made.

According to the character of the symptoms these

<sup>(</sup>a) Delivered at the Medical Graduates' College and Polyelinic.

-cases fall into two groups—(1) those in which the diagnosis of a perforated peptic ulcer is possible; (2) those in which the first symptoms which bring the patient under observation resemble those of appendicitis, or are produced by subphrenic abscess; in many of this second group the onset is gradual.

The following is a typical example of the first group:—A. G., æt. 39, was admitted to the London Hospital, June 3rd, 1906, six hours after a meal of tea and cake. Two hours after the meal he was seized with violent epigastric pain and vomiting. I saw him five hours after the onset of symptoms. There was There was

no history of previous gastric trouble of any kind.

His face was pale and drawn; the whole abdomen
was slightly retracted and was rigid, there was no superficial tenderness, but slight general deep tenderness, most marked in the epigastric region. pulse was 66, and his temperature 97°. It was obvious that he was suffering from a perforative lesion in the upper abdomen. From the location of the pain at the onset to the epigastrium, I concluded that it was stomach or duodenum, the age and sex of the patient pointed to the duodenum as the probable seat of the perforation.

I operated at once and opened the abdomen through the right rectus muscle, and found free gas in the peritoneal cavity and fluid around the stomach. The perforation was situated in the centre of a chronic ulcer of the first part of duodenum, and was the size of a pea with clean cut edges. I invaginated the ulcer with two layers of silk stitches, wiped the free fluid gently away, and, as the case was early, the ulcer chronic and the stitches produced some constriction of the duodenum, I did a gastro-enterostomy. He made an uneventful recovery, and I saw him two

months ago perfectly well.

Fortunately, this is the more usual type of per-foration, of the eleven cases seven fell into this group, and were diagnosed as a perforation of a peptic ulcer of stomach or duodenum. There is no reason why cases in this group should not be operated upon early if seeking medical advice soon after the onset of symptoms. The history of sudden onset of acute symptoms. The history of sudden onset of acute abdominal pain, often accompanied by vomiting in a healthy man, or in one who has suffered from dyspepsia; the rigid and retracted abdomen, without rise in pulse rate or temperature, should indicate surgical interference. It cannot be too often insisted upon that the sudden onset of acute abdominal pain in a healthy person, whether accompanied by vomiting or not, although there is no rise of pulse rate, almost always signifies a serious surgical condition, if rigidity of the abdomen exists, it is certain that it is a grave one, and that unless surgical help is sought at once it will be given too late.

It is one of the tragedies of surgical work that in some abdominal cases indications for operation are not present until it is too late to do good, some examples of perforated duodenal ulcer fall into this group. It is only by a close study of symptoms that are in many cases looked upon as slight that a diagnosis can be made before perforation has occurred. The symptoms of the perforation of a gastric ulcer are usually unmistakable, of a duodenal they are not always so; this is an additional reason why every effort should be made to diagnose the condition, and not be content with the position taken up by Ashurst

and Deaver.

As an example of perforation which may be mistaken for appendicitis, the following is instructive:

T. J., æt. 19, was admitted to the London Hospital, July 10th, 1907. Twelve hours before admission he had a sudden onset of abdominal pain; it was not very severe at first, for he worked for four hours, then it became so severe that he had to give up. The pain at first was a little above the umbilicus, but then settled in the right iliac fossa. There was no vomiting either at the onset or later.

He presented the appearance of a patient with a severe abdominal lesion. The abdomen was rigid and deeply tender, particularly in the right iliac fossa. His temperature was normal and his pulse 108. He had suffered from vague pain after food for three vears.

In this case the correct diagnosis was made, as the pain at the onset was above the umbilicus, and only later settled in the right iliac fossa, and from the history of previous dyspepsia.

I opened the abdomen through the right rectus, and found a large perforation in the centre of a chronic ulcer on the anterior surface of the first part of the ulcer on the anterior surface of the first part of the duodenum. The whole abdominal cavity was full of bile-stained fluid, with flakes of lymph. After closing the ulcer, I gently removed the fluid and drained through the right kidney pouch and suprapubically. The patient died 36 hours later. At the post-mortem examination no obvious cause for death was found, the ulcer was closed and no diffuse peritonitis was present.

As an example in which the diagnosis was not made,

the following is instructive.

A policeman, æt. 39, was admitted to the London Hospital, May 14th, 1908. He had not been feeling well for 14 days, but would have been at his work had he not had leave for the purpose of house shifting. He had had no definite symptoms, just "feeling out of sorts." He had never had any previous abdominal trouble. Two days before admission abdominal pain started very gradually; he vomited

for the first time 24 hours after its onset.

He was a powerfully-built, stout man, and when I saw him shortly after his admission to hospital he was lying comfortably in bed reading the paper. pulse and temperature were normal and his tongue clean and moist. The abdomen was not distended, but did not move well in the right iliac region, was slightly rigid here and deeply tender. I thought it to be the end of a subacute attack of appendicitis, and did not consider immediate operation necessary. had him put in Fowler's position, and stopped all feeding by the mouth, and saw him again twelve hours later. His pulse and temperature were unchanged, but the abdomen had become a little distended and the rigidity and tenderness were more marked. I operated immediately and opened the abdomen through the lower part of the right rectus muscle. Odourless fluid with large flakes of lymph came out, at once suggesting the correct diagnosis. After much difficulty I found the perforation in the centre of a chronic ulcer at the right and anterior part of the second portion of the duodenum. I closed it with difficulty, grafted a portion of omentum over it, and drained through the right kidney pouch, iliac fossa, and above the pubes. He died the next day. We were not allowed a post-mortem examination.

In this case the diagnosis was impossible, although duodenal ulcer was discussed; there was no preceding dyspepsia, no epigastric pain or rigidity, and those abdominal signs which were present were in the right iliac region. The fluid had trickled down along the colon and had only later become generalised. Ont of 57 cases of perforated duodenal ulcer collected by Moynihan the diagnosis of appendicitis was made in 18.

As an example of the gradual development of a subphrenic abscess as the result of the perforation of a duodenal ulcer, the following is a good example:-

B. M., æt. 19, was admitted to the London Hospital, May 5th, 1905. The illness began eight days before admission with slight pain in the upper right abdomen and occasional vomiting, but he was able to keep at work for four days, and then the pain suddenly became acute, involved the whole abdomen, and frequent vomiting set in. When I saw him the whole abdomen was rigid and distended, his pulse was 136 and temperature 99°, face drawn, and tongue dry. I opened and drained the abdomen, without searching for the cause as his condition was desperate; he died soon after. At the post-mortem examination a chronic ulcer of the junction of the first and second parts of the duodenum was found, surrounded by adhesions; this had perforated, causing a subphrenic abscess, which had later infected the whole peritoneal cavity, probably as the result of rupture.

In many cases an exact diagnosis of the seat of the perforation cannot be made before operation, but in a large proportion, 7 out of 11

of those I have treated, it is possible to diagnose the presence of a perforative lesion in the upper abdomen, and the diagnosis could have been made within an hour of perforation, all giving the absolutely sudden onset of acute abdominal pain, etc. The diagnosis in these cases between a perforation of a gastric and a duodenal ulcer cannot be made with any certainty, nor is it a matter of importance to do so, for a perforation of duodenal ulcer can be dealt with through the same incision as a gastric. It is only necessary to diagnose the occurrence of a catastrophe in the upper abdomen. In some cases the history of previous trouble leads to the correct diagnosis being made. It is important, however, to limit the diagnosis to perforation of a gastric or duodenal ulcer, and to exclude appendicitis, if possible. It does not add to the chances of the patient to have exploratory incisions in the lower as well as the upper abdomen. The situation of the pain at the onset is of great help; it is above the umbilicus in the group cases we are now considering; the onset of pain in the large majority of cases of appendicitis is in the umbilical region; the time of onset of the symptoms may be suggestive, duodenal and gastric ulcers rarely perforate during the night, the first attack of appendicitis occurs with frequency during the night or in the early morning.

In the second group of cases no rules can be laid down, every case must be gone into minutely and due regard paid to every point elicited in the previous history. The position of the pain at the onset should be inquired for, and weight laid on the region of greatest rigidity and tenderness, remembering that in many cases this will be in the right iliac fossa. If no definite diagnosis can be arrived at, I believe that the safest plan will be to operate when in any doubt; but if it is reasonably considered safe to wait, the patient should be kept absolutely at rest and nothing given by the mouth, and, above all, no morphia.

Treatment.—No time should be lost. If the patient

has to be taken to hospital or a nursing home, he should be transported on the back with the shoulders a little raised. Nothing should be given by the mouth—this should be the first rule in the treatment of all surgical abdominal emergencies. If the pain severe one injection of morphia may be given after the diagnosis is made and operation is decided upon, and no amount of apparent improvement should delay

operation.

The abdomen should be opened at once, either in the middle line or through the right rectus muscle. As a rule, when the perforation is into the free peritoneal cavity, as soon as the peritoneum is exposed it is seen to be blown out with free gas. On opening the peritoneum free fluid is usually present. The pyloric end of the stomach should be found, and the first and second parts of the duodenum carefully examined. After finding the perforation it should be closed by invagination with two layers of silk stitches; in many cases this is difficult; an omental graft may be stitched over the site of perforation when there is doubt as to its secure closure. The stomach should then be examined for other ulcers, for cases of simultaneous perforation of gastric and duodenal ulcers have been recorded. The upper abdomen should then be gently sponged with normal saline solution, and if the whole abdomen has been soiled gentle washing out after a tube has been placed immediately above the pubes through a separate incision will be beneficial. The question of gastro-enterostomy at the time of operation will often arise. On the whole, I am in favour of it being done at a later date, but it should be carried out in early cases when closure of the perforation produces stricture of the duodenum, or the ulcer which perforates is a chronic one.

Drainage is unnecessary unless peritonitis has supervened. In early cases drainage of the right renal pouch is sufficient, in later, a tube in the pelvis is also advisable. After operation, the patient should be propped up in bed, and unless the operation has been performed within a short time of perforation, all fluid withheld by the mouth. In early cases in which the perforation was completely closed, fluids can be

started at once.

It might be supposed that when once diagnosis has been made and the abdomen opened no further difficulty would arise, yet in one case in which I diagnosed perforation of a peptic ulcer, the presence of fat necrosis of the mesentery led to further search for the perforation being abandoned. It is often considered that the presence of fat necrosis indicates disease of the pancreas, but it is, of course, obvious that the escape of its fat splitting ferment by any other means would lead to the same result. I been awake to this fact, it is likely that the life of the patient would have been saved, as treatment was adopted early. The case is worthy of record to pre-

vent a similar mistake.

H. B., at 39, was admitted to the London Hospital, May 6th, 1904. Six hours before admission he was seized with abdominal pain, which was very severe. It started in the epigastric region, and was accompanied by vomiting. There was a history of dyspepsia for five or six months before. The abdomen was retracted and rigid, and there was deep tenderness in the epigastrium. Pulse 110, temperature 96°. I thought of the possibility of acute pancreatitis, as he was a stout, alcoholic man, but I dismissed this diagnosis and considered it a case of perforated gastric ulcer. I opened the abdomen above the umbilicus, yellowish, clear fluid with flakes of lymph came out, and there was the slimy feel about the omentum, so typical of fat necrosis. There was extensive fat necrosis of the mesentery and omentum. I tore through into the lesser sac and found a similar fluid to that in the general cavity. I drained here, and as the gall-bladder was distended I drained it

He died the following day. At the post-mortem examination it was found that an ulcer of the posterior surface of the first part of the duodenum had perforated into the lesser sac, and one of the anterior and right surface of the second part, into the general cavity.

At the present time I always examine the duodenum

in cases of fat necrosis.

(To be concluded in our next.)

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by James Sherren, F.R.C.S., Assistant Surgeon to the London Hospital, Surgeon to the Poplar Hospital for Accidents. Subject: "Duodenal Ulcer, its Diagnosis and Surgical Treatment."—(Concluded).

# ORIGINAL PAPERS.

# THREE CASES OF MALIGNANT DISEASE OF THE NASO-PHARYNX

BY W. STUART-LOW, F.R.C.S. ENG., Surgeon at Central London Throat, Nose and Ear Hospital, and Lecturer on Practical Otology at the Post-Graduate College.

FOR the successful eradication of malignant disease of the naso-pharynx it is imperative to operate at the earliest possible moment after the diagnosis has been made. Even should the main object in operating be only to relieve and palliate, no hesitation or delay should take place. While every effort must be exerted to remove all diseased tissue, it is most essential to conserve the structures in the pharyngeal region in every way possible, since the comfort of the patient, after operating in this region, largely depends on being able to swallow and breathe without pain, spasm or regurgitation.

CASE I.

The first case was that of a woman, æt. 64, sent up by her doctor from Luton to my clinic at the Central London Throat, Nose and Ear Hospital. in consequence of increasing discomfort in the throat and dysphagia.

She gave a history of having felt a lump in the

throat for eighteen months, and that it had increased much in size recently. The difficulty in swallowing had only come on during the last month.

She was a woman of small stature and healthy,

thin and wiry, and of active habits.

On inspecting the pharnyx, the soft palate was seen to be stretched and to bulge forward very much, especially on the left side. The naso-pharynx and the upper half of the oro-pharynx were occupied by a growth of deep red colour and rounded surface. On palpation the palate felt tense, being stretched over a firm substance behind, and this also felt firm but resilient on pressure. The growth had in-corporated itself with the soft palate on the left side. A piece was punched out, and Dr. Wingrave gave his opinion that it was of an endotheliomatous nature.

There were no glands enlarged on either side of the neck, and but little bleeding occurred after the

piece for the pathologist was taken away.

She was admitted to the hospital at once, and operated upon the following day, as it was considered that, if promptly performed, the prognosis was not unfavourable.

As from the clinical appearance of the tumour considerable bleeding was anticipated, laryngotomy was first performed, and the anæsthetic administered through this tube, a large captive sponge

being firmly fixed in the pharynx.

The soft palate was next divided through nearly its whole length over the growth. It was found that the enlargement could be shelled out from the lateral wall of the pharnyx, but had to be dissected off from the soft palate.

The hæmorrhage was rather free, but the captive sponge effectually prevented any blood entering the larynx. Three silk stitches were inserted to bring the two halves of the soft palate together, the larvingotomy tube removed, and the incision at once closed. The only after-treatment consisted in the employment of a solution of peroxide of hydrogen to spray the pharynx frequently.

She made an uninterrupted recovery, returning home in ten days. This patient was seen a few weeks ago, and no recurrence had taken place; it is now twelve months since the removal of the

tumour.

# CASE II.

The patient, a man, æt. 35, a printer by trade, was sent to the Central London Throat, Nose and Ear Hospital by Dr. Lathbury, of Dunstable, on account of increasing deafness, especially in the right ear, nasal obstruction and intonation, recurrent nasal hæmorrhage and painful cervical swell-

He had been subject to attacks of influenza for years, but otherwise his general health had been During the last year he had felt weak and easily tired, and had experienced some difficulty in breathing and swallowing at times. He had lost the sense of smell during the last few weeks, and had suffered much from headaches, the pain starting in the mass of glands on the right side of the neck.

The nasal obstruction was of three months' duration and was getting gradually worse. The deafness was of five weeks' standing, but the nasal hæmorrhage was of recent origin. He had a large mass of soft, freely-movable glands in the posterior cervical triangle, extending forwards under the sterno-mastoid muscle. This had given rise to a considerable amount of pain for a fortnight, preventing sleep.

On the left side of the neck there existed a

smaller swelling in the anterior triangle below the angle of the jaw. On inspecting the naso-pharynx it was seen to be filled with a fleshy-like mass having an irregular surface, and on palpation a soft substance was felt occupying the whole cavity. This bled very freely on palpation. It seemed to be attached to the roof by a broad indefinable base. A piece was removed for microscopic examination, when severe hæmorrhage occurred necessitating plugging with gauze soaked in a solution of adrenalin.

His heart being weak and dilated, and his spleen and liver enlarged, it was not thought safe to give a general anæsthetic; it was therefore decided to trust to local anæsthesia-viz., an injection of a

I per cent. cocaine solution.
Two drachms of this solution having been injected over the site of the skin incisions, the large mass of glands on the left side was first excised. He stood this so well that it was determined to remove the other enlarged glands, and perform laryngotomy

also under local anæsthesia next day.

Laryngotomy having been rapidly performed and the glands on the right side excised, the pharynx was firmly plugged with a large captive sponge, and the growth in the naso-pharynx removed with forceps, bent scoops and scrapers. The bleeding was very free indeed, making it necessary to again plug the naso-pharynx with a large gauze plug soaked in adrenalin chloride solution, and to wait five minutes before resuming the scraping off of the remainder of the growth. This having been satisfactorily accomplished, the naso-pharynx was firmly packed with a long gauze plug and the end brought through the mouth and secured.

Next day this plug was removed. There was no recurrence of the bleeding, and the patient made an uninterrupted recovery, returning home in six days

from the date of the first operation.

Immediately after the last operation, and before the patient was taken from the table, he was noticed to have much ecchymosis of the lids of the right eye-a veritable black eye. This gradually disappeared, but had not quite gone when he left for home. It doubtless testified to the thoroughness of the scraping, being most likely caused by interference with the perorbital venous circulation from rupture of veins leading into the pharynx.

Dr. Wingrave reported the growth to be one of endothelial sarcoma. The case proves the value of local anæsthesia in reducing to a minimum the risks of such an operation, and the imperativeness and importance of removing such malignant

growths without hesitation or delay.

#### CASE III.

T. P., a man, æt. 45, a cleaner in the employment of the Great Northern Railway, came to the clinic complaining chiefly of deafness in the left ear of a few months' standing. He also had an occasional stuffiness in the nose, especially on the left side, and there had been some recurrent bleeding from the nose. He had not much pain.

He was a thin, emaciated-looking man, but there was nothing in his past history bearing on his present condition. He had for the last fifteen years been engaged in a most dusty occupation-

viz., sweeping out railway carriages.

There were no external appearances of note-no glandular enlargements. On examining the throat the first thing to arrest the attention was the slight movement of the palate. On inspecting the naso-pharynx, on about the middle of the posterior wall, a raised ulcerated surface was seen; this extended on to the left lateral wall, and no doubt had invaded the Eustachian tube, thus accounting for the deafness in this ear. On palpation the ulcer was found to be more extensive than it appeared, and very hard. A piece was pinched off, and Dr. Wingrave pronounced it to be epitheliomatous.

It appeared that during long hours he had for years worked in his very dusty occupation. He was a very good example of malignant disease arising

in a hypomyxomatous subject.

The writer has observed a large number of cases of malignant disease in the regions of the throat and nose, and invariably hypomyia of the mucous membrane has been present, as shown by the shrivelled turbinals, and thin, dry membranes.

The patient was taken into the hospital for rest and treatment, but an operation was not undertaken, as it was not thought possible to remove all the growth. He was therefore treated with mucin both locally, internally, and hypodermically.(a) He improved in every way, gaining in weight, eating his food well, sleeping better, and losing all his pain in the throat. The growth became much softer and ceased to increase, soon presenting a clean surface. The fætor of his breath, which had been very marked, also disappeared.

After being an in-patient for three weeks, he was again treated in the out-patient department. He continued to have this treatment for five months, and there was a steady improvement for the first three months, showing what the mucin treatment of malignant disease can be depended upon to dowiz, to relieve pain and retard the growth of the tumour for a time

The cancer, however, got out of hand during the last month, and he died in the workhouse infirmary five months after the commencement of the treatment, during the absence of the writer on his summer holiday.

## CASE OF MYASTHENIA GRAVIS.

BY W. B. WARRINGTON, M.D., F.R.C.P.,

Physician to the Northern Hospital and to the Eye and Bar Infirmary, Liverpool; Lecturer in the University of Liverpool,

[Patient shown at the Liverpool Medical Institution.]

ELIZ. S., æt. 31, with no medical antecedents of importance and in previous good health, about a year ago noticed that she became very readily latigued and was able only to walk a short distance. For the last few months difficulty in swallowing and occasionally regurgitation of fluid through the nose had troubled her, she made complaint of occasional double vision. The fatigue on any exertion has recently greatly increased and has been accompanied by breathlessness, so that just before she applied for relief she was barely able to walk without assistance.

The patient was seen to be of poor general muscular development, but one could hardly speak of any localised muscular atrophy, though the falling-in of the cheeks and the lack of expression of the face at once arrested attention. Possibly the deltoid muscles were wasted more than other muscles of the limbs.

Examination was first directed to the tongue and soft palate. The tongue was rather wasted and could be protruded only to a slight extent, and then without force, though all its movements could be performed. It presented some resemblance to the tongue of progressive muscular atrophy, but the atrophy was far less marked and no fibrillary twitchings were observed.

(a) "See "Mucous Membranes and Mucin and Mulignancy." W Steart-Low. Published by Bailliere, Tindall and Cox

The palate hung rather low in the mouth, but on phonation was raised in a normal manner; the movement gradually lessened on repetition, and finally it remained as an almost motionless veil.

The vocal cords were seen to close and open normally, but repeated attempts at phonation greatly exhausted the patient, so that this examination had to be abandoned; it could be said, however, that a sustained approximation of the cords, as in singing a high note, was impossible.

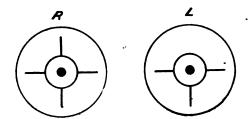
The lips could be approximated, but very little force was required to draw them apart; she could not whistle, and the explosives b and p were pro-

duced in an ill-defined manner.

On asking her to "show the teeth," it was noticed that the angles of the mouth were not drawn at all outwards, but only upwards, thus giving the characteristic appearance spoken of by Sir Wm. Gowers as the nasal snarl. The eyelids could be gently and completely closed, but the strongest endeavour of the patient could not prevent them being drawn apart by a slight effort of the observer.

The upper eyelid moved well upwards and was accompanied by the synergic contraction of the frontalis muscle; thus ptosis, an almost constant appearance in this disease, was absent. If, however, one asked the patient to repeatedly raise the eyelid, it was seen that this movement became more feeble, so that some degree of ptosis, but never to a great extent, developed. It was noticed that the contraction of the frontalis muscles ceased sometimes before the ptosis became visible

Neither eye could ever be moved to the external canthus, movement ceasing at about one-eighth of an inch from that point, and further effort was accompanied by slight wobbly movements of eyeballs. When first tested the other external eye muscles acted normally, but a repetition of endcavour to move the eyeballs in all directions soon led to obvious paresis of the upward movement of the eyes, especially of the left, which could not be moved beyond the horizontal plane. Other movements were less affected. In the stage of most exhaustion the remaining degree of mobility might be graphically represented thus by the length of the lines drawn from an inner circle indicating the circumference of the cornea.



The jaw could be opened with fair force, but only closed very feebly, so that one could with impunity permit the patient to bite one's finger.

The muscles moving the neck were very weak; at times there was the greatest difficulty in raising the head from the pillow, and when sitting or standing the head could rarely be kept erect, falling in any direction, as determined by the action of gravity for the moment. The sterno-mastoids were notably feeble in their action. The supra- and infra-hyoid muscles were fairly strong, as shown by the ascent and descent of the larynx during phonation and swallowing.

In the upper limbs the grasp of the hands was fairly strong, though after prolonged effort they became feeble. The biceps grasp and pectorales

acted well, though the power of flexion of the forearm soon tired

The biceps tired even much more readily, and the deltoid most of all; after eight endeavours the patient was no more able to abduct the arm from the side.

In the lower limbs the chief weakness seemed to be in the muscles passing from the pelvic girdle to the thigh. At one time she could just manage to raise a foot from the ground on to a chair; at another not even on to a low buffet. She could not succeed in raising herself from a chair into the erect position more than eight or ten times. Such efforts produced marked exhaustion and rapidity of breathing, in which the diaphragm took the leading part, the intercostal muscles failing soon to act well, whilst painful, but futile, efforts to use the extrinsic muscles of respiration were obvious.

So, also, to raise the body from the horizontal to the sitting posture was impossible.

The feet could be moved easily and did not show the fatigue so readily induced in the thighs. The

gait was slow and uncertain; one had constantly to beware lest the patient fell. She could, with some assistance, walk a dozen yards, and was then overcome by fatigue and breathlessness.

The reflexes of all kinds were normal and sensation undisturbed. The electric reactions showed with a number of muscles, notably the masseters, deltoids and triceps-what is called the "myasthenic reaction," i.e., after several repeated single faradic excitations, they failed to react, and similarly when one electrode was kept continuously on the muscle, the tetanus so resulting was of short duration and soon the muscle remained flaccid, this flaccidity being preceded by a few irregular flickers of the muscle fibre.

A constant characteristic observed during the patient's residence in the hospital was the variability in the degree of the various muscular weaknesses. This variability must be ranked as equal in importance to the phenomena of the rapidly-induced exhaustion; indeed, it is possible that these lastmentioned symptoms may not be obvious, whilst the extreme variability from day to day may be the striking feature.

#### REMARKS.

I do not purpose to say anything of the history or our present knowledge of this peculiar disease. It is rare; possibly, as the symptoms become better known, it will be found to be more frequent in occurrence. This and another case I saw some years ago drifted casually into the out-patient department; this had been called neurasthenia, that hysteria. Both these diagnoses were serious errors and may be disastrous, for in at least fifty per cent. this disease ends fatally by sudden respiratory failure.

If the grave organic nature of the symptoms be at first recognised, then later the observer may enter into a consideration of its exact diagnosis.

# THE X-RAY TREATMENT OF TUBERCULAR GLANDS. (a)

By A. HOWARD PIRIE, B.Sc., M.D.,

Physician in charge of the X-Ray Department of Mount Vernon Hospital for Consumption; Chief Assistant in X-Ray Department at 8t. Barthelomew's Hospital.

REPORTS have appeared in medical papers during the last five years of cases of tubercular glands which have been cured by the application of X-rays. On the other hand, some X-ray workers have had no success by means of this

(a) Paper read before the Cheisea Clinical Society, March 9th, 1909.

treatment. One has difficulty in reconciling these results, but still more difficulty in discovering the dose of X-rays that has been given to the patient. Probably the successful cases have had a sufficient dose, and the unsuccessful cases have not had a sufficient dose. People are so afraid of giving an overdose of X-rays that they go to the other extreme and do not give enough. It is only by most careful measurement of X-rays that one dare give a patient sufficient to bring about a cure.

EFFECT OF X-RAYS ON TUBERCULAR GLANDS. The effect of what I call an efficient dose of X-rays may be twofold:-

(1) It may raise the opsonic index from below normal to normal.

(2) It may kill giant cells which are forming. Dealing with the first statement, a certain amount of good work has been done in this country and in America, which has shown that after a tubercular patient has received an efficient dose of X-rays the opsonic index slowly rises.

There is not a sudden change like that which follows the injection of tuberculin. I have kept this fact in mind while treating my patients, but I have also been guided by the other theory, viz., that X-rays kill giant cells. Let me briefly give my reasons for this statement. Quickly growing cells are more easily killed by X-rays than are slowly growing cells. This is now a well-established fact, and I may remind you that the cells most easily killed in the human body are those cells which grow quickly at the root of a hair and cause the growth of the hair, the reproducing cells of the testicle (these are very easily killed, as any X-ray worker can tell you), all gland cells such as those of the skin, of the hairs, and of the thyroid, and the cells of young growing animals. Giant cells at one time in their life history were quickly growing, this has been shown by Podwyssotzki and Pirone (a), who experimented in the formation of giant cells by a method of freezing and thawing a rabbit's ear. They found that giant cells formed in three days. Any cell which grows into a giant cell in three days is a rapidly growing cell, and is therefore easily killed by X-rays. Microscopic sections of giant cells show the presence of tubercle bacilli in them. These bacilli appear to me to have made their home in the giant cell, to have filled it with their poison, and thus to be proof against the attack of leucocytes. How like they are to a larva (whose name I do not know) which invades an oak tree. The oak tree cannot throw it off, and in its effort to do so throws a protecting house around the larva, and the larva thus lives as an unwelcome guest in a gall nut. If that gall nut is destroyed the larva is set free and is devoured by a bird: so a tubercle bacillus, when unprotected by its giant cell is devoured by a leucocyte. I know that some hold a contrary view to this, but I am here fitting theory to facts, and not facts to theory. The action of X-rays is therefore to destroy the giant cell while it is forming, so that the tubercle bacilli shall have no place of defence. It is therefore imperative (1) to get the case early, while the glands are growing larger, and before the gland has begun to grow fluid; (2) to give a sufficient dose of X-rays once a week, so that the week's crop of

Archives des Sciences Biologiques," St. Petersburg, 1906. Vol XII, p. 214.

giant cells are killed before reaching maturity, and at the same time not to injure the patient's skin by X-rays.

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METHOD AND DOSE OF X-RAYS USED. Keeping these theories in mind I now treat tuberculous glands with the maximum dose that the skin will stand once a week for a prolonged period. I find this dose is one-third of an epilation dose. The latter is the dose which just causes the hairs to fall out of a child's scalp. I measure this by means of Sabouraud's method, and confirm this measurement by means of my water meter. Some patients can safely have more than this dose. In order to measure one third of an epilation dose the tube should be removed to such a distance from the skin that the square of the distance in centimetres is to the square of the distance used in Sabouraud's method is as 3: 1. At the same time I protect the skin by several layers of towel, which stop ultra violet rays which are so harmful to the skin, as well as the less penetrating X-rays which would be absorbed at the surface of the skin and do

no good to the gland beneath. It reminds one

Three stimulating doses = one epilating dose. Two epilating doses = one inflammatory dose. Three epilating doses = one X-ray burn of 1st degree.

Medical men should order X-rays as they do drugs. Thus I would recommend their use as follows :-

For Ringworm—one epilating dose.

For Sycosis—one epilating dose.

For Rodent Ulcer-one epilating dose every three weeks.

For Tubercular Glands-one stimulating dose once a week.

For Acne Vulgaris—one stimulating dose every five days

For Idiopathic Keloid-one stimulating dose once a week, and so on, for other diseases which are definitely cured by means of X-rays.

To illustrate the efficiency of these doses I show you the following lantern slides. I have dealt at considerable length on the dose of X-rays, because it is all important in the efficient and successful treatment of tubercular glands by means of X-rays.







TUBERCULOUS GLANDS TREATED BY X-RAYS.

First photo. shows the condition when X-ray treatment was begun. Second photo. shows the condition after three months' treatment. Third photo. shows the condition nine months after beginning X-ray treatment.

very much of the greased paper a baker puts round a cake to keep it from burning on the surface.

Erroneous Views on X-ray Dose. One is often asked "How long do you expose the patient to the X-rays?" The question is as absurd as to ask a photographer "How long does it take to print a photograph?" The photographer might truthfully remark "Between three minutes and three months, depending on the light." So with X-rays; I have given the same dose in two and a half minutes, and in three hours by having rays of different strength. It is as important to measure the dose of X-rays as it is to measure drugs, and in large, busy hospitals it is often neglected, as it is a troublesome process. At St. Bartholomew's Hospital I have had the time and opportunity to measure carefully the dose of every patient I have treated, and the results have been very gratifying as you will see by the following cases.

For the purpose of treatment I classify X-ray doses as follows :-

X-RAY DOSE TABLE.

One stimulating dose = smallest useful X-ray unit.

# CASES.

1-6, results in various diseases of measured doses of X-rays.

7-13, results of measured doses of X-rays in cases of tubercular glands.

14, results of measured doses of X-rays in case

of lymphadenoma.

(I) Sycosis.—A man, æt. 40, with sycosis affecting the whole beard is shown in the first slide. The second slide shows the condition Treatment—one epilating dose.

(2) Rodent Ulcer.-The first slide shows a man, æt. 73, with a rodent ulcer 3" by 2" on his face. The second picture shows him cured. Treatment—

one epilating dose every three weeks.

(3) Ringworm.—First picture shows a child temporarily bald from the effect of one epilating dose of X-rays. Second photograph shows good growth of healthy hair. Treatment-one epilating dose of X-rays.

(4) Rodent Ulcer.—A similar case to (2).

(5) Keloid.—First photo. shows threei diopathic keloids. Second shows the condition cured. Treatment—one stimulating dose every week for six months, and every fortnight or three weeks for another three months.

(6) Lupus.—First photograph shows lupus affecting the nose and both cheeks. Second photograph shows the condition cured. Treatment—one stimulating dose once and sometimes twice a week, till a very slight reaction appeared, and once a week thereafter. Duration of treatment was eleven months.

Cases of Tubercular Glands.

- (7) First photograph shows a child with a mass of glands on the side of the neck. The second photograph shows the condition cured. *Treatment*—one stimulating dose once a week for nine months.
- (8) A similar case to (7). Treatment lasted fifteen months.
- (9) A similar case to (7). The glands were specially large and plentiful in this case, and the treatment lasted eighteen months.
  - (10) A similar case to (7).
- (10) A similar case to (7). Treatment three months.
  - (11) Similar case.
  - (12) Similar case.
- (13) Lymphadenoma.—First photograph shows a great mass of glands on side of boy's neck with scars of five operations for removal of glands. After each operation the glands grew quickly, and the surgeon gave up operating on them. The second photograph shows the condition nearly cured. Treatment—one stimulating dose once a week for two months, and twice a week thereafter for four months. (This case for demonstration.)

In applying X-rays it is very important to remember that the intensity of the rays varies inversely as the square of the distance at which the patient is placed, and that by using this rule it is possible to give a gland approximately the same dose as the skin covering it. Thus suppose a gland lies 2 cm.s. from the surface of the skin, and that the skin is placed 10 cm.s. from the source of X-rays. Then (supposing that none of the rays were absorbed by the skin) the intensity of the rays at the surface of the skin is to their intensity at the gland as (the squares of the distances) 144: 100—i.e., nearly in the proportion of 3:2. Now suppose the skin is removed to a distance of 100 cm.s., then the gland is 102 cm.s. distant and the skin receives 10,404 units while the gland receives 10,000 units -i.e., nearly in the proportion of 1.04 to 1, which means that the skin and the gland receive nearly the same dose.

Thus the skin will stand the action of the X-rays much better when far removed from the source of the rays, but the time of exposure has to be made much longer, in order to let the gland receive its required dose. In order to carry out this method of dosage at a distance, I have prepared a table which will be published in the Proceedings of the Royal Society of Medicine this month, but it is too technical to deal with at present.

CONCLUSION.

Tubercular glands in the neck can be successfully treated both before and after they have broken down. The best time to begin treatment is when the glands are growing larger. On two occasions I have seen a fluid gland become absorbed without opening on the surface. Usually when a gland has become fluid it opens on the surface, and heals in a month when X-ray treatment is going on. Rather than let the gland burst when it is fluid I intend, when I find a case, to aseptically aspirate the fluid and go on with X-ray treatment.

The contents are sterile, and their removal must take place before healing takes place.

The cosmetic effect when X-ray treatment is begun early is excellent, as no scar is left. The glands shrink to small, hard nodules of scar tissue, which remain under the skin, do no harm, and are not visible though they may be felt. A combination of X-ray treatment and injection of tuberculin has in the hands of M. Bergonié proved very efficacious. Tubercular glands often disappear spontaneously, and in my cases I may have done little good, but I have always been careful to do no harm. By the treatment there is no disastrous activity, and it is sometimes the height of wisdom to do nothing. The first quality required of a physician is that he shall be an honest man. Science comes after that. The evil which a medical man does not do should be counted to him for righteousness. No scar is left by this treatment, and there is no injury to nerves, which not infrequently follows an extensive operation.

#### **OPERATING THEATRES.**

ST. PETER'S HOSPITAL FOR URINARY DISEASES.
Two Prostatic Cases.—First Case.—Mr. Swin-

ORD EDWARDS operated on a man, æt. 68, who had been admitted for cystitis and enlarged prostate about a month previously. The patient on admission was thin, pale and in anything but good condition. His urine was alkaline, foul-smelling, with a low percentage of urea. Retention was complete. The prostate, as felt per rectum, was enlarged, softish, and movable, and it was evidently a good case for enucleation if the bladder could be brought into a healthy state. the bladder could be brought into a healthy state. For this purpose Mr. Edwards had opened the bladder and drained it three weeks previously. The percentage of urea having increased, and the cystitis being practically cured, it was thought a fitting time to proceed to the enucleation. It might be mentioned, Mr. Edwards said, that the supra-pubic cystotomy had been performed under local anæsthesia, the anæsthetic used being a 4 per cent. solution each of cocaine and eucaine. The operation this time was conducted under spinal anæsthesia. After draining off about a drachm of cerebro-spinal fluid, a solution of novocain and manitol was injected; an interval of ten minutes was allowed to elapse, and the supra-pubic sinus opened up sufficiently to allow the introduction of the finger comfortably into the bladder. The enucleation was completed in thirty seconds, and the prostate was delivered whole, although split down the anterior commissure, which splitting occurred in extracting the organ from the bladder through an unusually small and unyielding opening. Although the prostate stripped with the greatest ease, there was iather more bleeding attending the operation than is usual, and sensation to pain was not completely abolished, though no doubt modified. The chief pain complained of was when the sutures were being inserted after the introduction of the supra-pubic drain.

CASE 2.—This was that of a man, æt. 80. The patient was excessively stout. On him, as in the previous case, supra-pubic cystotomy had been performed a fortnight previously by Mr. Edwards for the relief of retention and for the purposes of bladder drainage, the man, on his admission to hospital, having been in a very bad condition with reference to his urinary organs. As his heart appeared to be weak, and he suffered with an old bronchial affection, it was deemed wiser to attempt enucleation under spinal anæsthesia rather than general, for which purpose a lumbar puncture was performed, as in the previous case, the patient being in the sitting posture and stooping forwards, in order to render the spinal column as convex as possible. After two vain attempts to tap the cerebro-spinal fluid, it was reached at the third essay, and after the withdrawal of a certain amount,

the same anæsthetic compound was injected as in the previous case. After a delay of about ten minutes, the suprapubic wound was enlarged upwards and downwards, and the inner fibres of the recti divided on either Bimanual enucleation of the prostate was now attempted. The left side of the prostate was stripped by the right index finger, whilst considerable pressure upwards was effected by two fingers of the left hand inserted into the rectum. It was now found quite impossible, owing to the depth of the prostate from the abdominal wall, to reach the centre limits of the gland through the limited incision which had been made, although it allowed the introduction of two fingers. About this time the patient became somewhat faint, and Mr. Edwards was debating whether he would stand a larger exposure of the bladder, allowing sufficient ancision to introduce the hand, when the patient's pulse ceased and respiration became very feeble. Further respiration became very record. Further repetative measures were desisted from, and artificial respiration was at once carried out, combined with injection of hot brandy and water into the rectum, and the subcutaneous administration of atropine. After about a quarter of an hour the patient's condition improved, so that the wound was sewn up after the insertion of a supra-pubic drain and thorough bladder irrigation. The patient was returned to the ward.

Mr. Edwards said it was uncertain what part lumbar at æsthesia had produced in this patient's collapse. The two cases that he had just operated upon would not give the onlooker probably a very favourable impression of this method of anæsthesia, but he would like to observe that during the past nine months he had carried out many cases of enucleation of the prostate under spinal analgesia, with complete success not only as far as freedom of pain and lack of shock to the patient were concerned, but also as far as facility in manipulation was concerned, owing to lack of muscular rigidity or spasm. This last case shows, he thought how difficult may be an enucleation in corpulent individuals, in some cases necessitating the introduction of more than one finger-nay, of the whole four-in order to strip the prostate successfully by reaching to its farthest limits. It might be noted, he remarked, that both these cases were secondary operations, and although no doubt the mortality of this operation is considerably lowered by r.ot proceeding to enucleate when the bladder is in a foul condition, the performance of a primary cystotomy renders the second operation more difficult owing to the fact that the peritoneum is often bound down, and would be liable to injury, being almost sure to be injured by anything like a free incision upwards; besides, the parts around the wound become contracted and un-

yielding.

Both these cases are doing well, but it is quite a problem whether the octogenarian will ever be in a good enough condition to warrant the extensive operation necessary for the removal of his prostate.

#### TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, MARCH 19TH, 1909.

Dr. E. H. TAYLOR in the Chair.

#### LATERAL PHARYNGOTOMY.

MR. P. J. DEMPSEY exhibited a case of lateral pharyngotomy, The patient had consulted him for hoarseness. He had no pain, but his voice got tired more easily than it ought, and he had a sensation of something in his throat. On examination, by merely depressing the tongue on the right side, the beginning of a small pear-shaped swelling was to be seen, corresponding almost identically to the posterior pillar of the fauces. The growth was found to extend down into the epiglottis. On palpation there was evidence of fluid, and it appeared to be a branchial cyst. The

patient, who had to use his voice in preaching, decided to have an operation. If the cyst were branchial, it would probably have diverticula in various directions, and could not be got at from the inside; he therefore thought it best to take it away from without. The operation was performed on November 26th as if it was a lateral pharyngotomy, although the pharynx was not opened. When he opened the cyst, about two tablespoonfuls of clear fluid came out. The wall of the cyst was curetted and packed with gauze, which was kept in for 48 hours, and then removed and a drainage-tube inserted. The tube was kept in about a week. No fluid came, and there were no signs of the cyst refilling. The recovery was uneventful. He had pain on swallowing after the operation, which disappeared in a few days. He had no trouble since with his voice.

The Chairman said the two main things in a case of the kind were thorough asepsis and the complete removal of the cyst wall. Both had been fully accomplished in this case.

Mr. R. H. Woods exhibited a case of

EXTIRPATION OF THE LARYNX, WITH A NEW APPARATUS FOR VOICE PRODUCTION.

The patient, a man, et. 42, had consulted him two months ago, complaining of pain in swallowing. On examination there was a large tumour, occupying the right half of the larynx and extending up to the middle line, which proved, on microscopic examination, to be a squamous carcinoma. Eight weeks ago, assisted by the Chairman, he opened the region of the carotid sheath and dissected out obviously carcinomatous glands. The glands were adherent, and a couple of inches of the internal jugular vein were excised on the right side. After a preliminary tracheotomy the larynx was opened, and as there was little chance of a hemilaryngotomy curing the case, the whole larynx was extirpated. The trachea was sutured to the skin, and the sac of the pharynx completely cut off from communication with the respiratory tract. In order to enable the patient to speak, it occurred to him that he might be able to convert the sound made by a reed into speech. Accordingly, he fixed a reed in a tube. By putting it into the nose and dropping it over the soft palate, and by putting the other end into the trachea he was able to blow and make the reed vibrate. A valve was used to take in the air, and when he had his chest full he put his finger to the end, and the air was pressed into the tube. Mr. Woods then inserted the instrument, and the patient, after a salutation to the section, counted from one to ten.
Mr. DEMPSEY said the case showed the results that

Mr. Dempsey said the case showed the results that could be obtained in laryngectomies when the pharynx was cut off from the respiratory tract. The real success of such a case was due to the avoidance of the danger of pneumonia, which killed nine out of ten patients formerly. Professor Gluck had performed at complete laryngectomies in the past year or two, and had not had a single death. It was too soon, however, to judge of the question of recurrence.

to judge of the question of recurrence.

Mr. W. L. Murrhy suggested the trying of a smaller tube.

The CHAIRMAN said he was much struck with the comparative ease with which Mr. Woods was able to close the pharyngeal tube.

The Secretary inquired as to the effect of the operation on the man's hope of life. Horses which were tracheotomised improved for a time, but after a while went rapidly to the bad.

Mr. Stokes asked if the patient could cough.

Mr. Woods, in reply, said there was no trouble in getting a pharyngeal wall; even after the larynx was taken away there was plenty of wall to complete a very good tube. Before doing the extirpation he thought it wise to give the patient an anti-streptococcus vaccine so as to raise his opsonic index, and his temperature only rose to 100° for two days, and then fell to normal. This was, under the circumstances, remarkable, and he thought some of the credit was due to the preliminary vaccination. The tube was sufficiently small to pass through the nose, and a smaller one would require a smaller reed, which would give less power to the voice. He had had a case of

tracheotomy about 15 years ago, and the man was in the best of health though still wearing a tube. man before them could make a respiratory effort capable of clearing off any secretion in his windpipe. He was fed after the operation by a tube through his nose. This was kept until he was able to swallow, about ten days afterwards.

Mr. W. L. MURPHY exhibited a rhinolith removed from a woman. It was wedged underneath the in-ferior turbinal, and was easy to get out. The dis-charge ceased immediately. The composition of the rhinolith was calcium carbonate and phosphate, with some organic substance resembling cellulose.

The Secretary said he did not see the exact origin of a rhinolith where there was no nucleus of a foreign body, or that any small body, such as a piece of mucus, should remain in the nose such a long time as to make a nucleus.

Mr. E. T. TAYLOR exhibited an

ECTOPIC HYDRONEPHROTIC KIDNEY

removed from a young woman about a fortnight ago. The clinical symptoms were strongly indicative of appendicitis. On palpation over her right iliac fossa he was able to determine deep fluctuation, and as she appeared to be very ill he decided to operate that evening, and to cut down over the fluctuating area with local anæsthesia. He was surprised to reach the parietal peritoneum without any evidence of pus. When he opened it, his finger passed over a surface that was bigger than a normal cæcum, and he thought it might be an ovarian cyst with a twisted pedicle. He extended the incision under chloroform, but found no pedicle. He punctured a large swelling which was fluctuating and tense, and a quantity of fluid escaped. The tissue at the edge of the opening was evidently renal. He put a tube into the kidney and drained the hydronephrosis, and after ten days removed the kidney, having a removely esticated himself that the latter was previously satisfied himself that the left kidney was healthy. The case showed that even where all typical features of appendicitis were present, they might come on a case that had nothing whatever to say to either the cæcum or appendix.

Mr. HAUGHTON said his experience of local anæsthesia was that when they got to the peritoneum they

came on extremely sensitive material.

Dr. Peacocke said he saw the girl only three days before he sent her into hospital, and he never was more positive in his life that he was dealing with appendicitis. He had great hopes, from past experience, that the girl would live a long life with only one

The Secretary (Mr. A. J. Blayney) said the frequency with which appendicitis was met with made them tend to come to the conclusion that most rightside pains were due to it; but he had seen a fair number of cases which proved to be otherwise. He had operated on somewhat similar cases as regards the pathological findings, though the symptoms were not the same. In one case there were oxalate of lime stones, which had probably excited a considerable amount of inflammatory reaction, and led to narrowing of the ureter.

Mr. TAYLOR, in reply, said the strength of novo-caine used in Berne was one tabloid dissolved in 10 c.c. of sterile water. He had used it approxi-mately at that strength, but often weaker. When getting down through the muscles towards the parietal peritoneum he always injected freely, and tried to produce ædema of the extra-peritoneal tissue. There was some pus mixed with the urine in the distended pelvis. After the operation the temperature rose to 1000, but the morning after the pain had gone, and the temperature fell to normal and remained so. The wound had practically healed, and the patient was perfectly well.

Mr. W. S. HAUGHTON exhibited a specimen of

SARCOMA OF ORBIT AND UPPER JAW from a girl, æt. about 28. For six months she had suffered from discomfort and pain in the region, and prominence of the eye-ball was noticed. She had a good deal of cedema. For a month the growth of the tumour had been rapid and the pain considerable, and the case seemed hopeless. The girl was blind. On

operating he found that the muscles were involved, and he decided to sacrifice them and the branches of the facial nerve. As a preliminary measure he ligatured the external cartoid artery, and thus controlled and limited the hæmorrhage. The roof of the antrum and the floor of the orbit were penetrated by the tumour. They had to enucleate the eyeball, and found underneath a mass of sarcomatous tissue. The septic condition following such an operation was a great trial as food particles and sloughing tissue decomposed in the mouth. He irrigated the cavity with saline fluids at frequent intervals: every half-hour for 48 hours the mouth was washed out copiously. She had very little rise of temperature, almost no decomposition in the mouth; she had practically no pain, and an uneventful convalescence.

Mr. HAUGHTON also exhibited a specimen of carcinoma removed from male breast by Halsted's method. The diagnosis had to be taken without prejudice, as it had not yet been confirmed microscopically. The patient was a farmer, at. 56. In the course of his work, one leg of a ladder, on which was a man weighing 14 st., came on his chest. Afterwards he noticed pain in the right pectoral muscle, and a few months ago a tumour appeared in the region of the nipple with a slight discharge. The tumour grew to the size of a small walnut, and was extremely hard. He had a few hard glands in the axilla. The operation was the ordinary typical one described by Halsted. It was the first cancer in the male breast he had seen, while he had seen 200 to 300 cases of cancer of the female

The CHAIRMAN said that in performing excision of the upper jaw he had performed a preliminary laryngotomy and plugged the pharynx, and found that he could proceed leisurely without the risk of blood entering the air-passages. In his experience such cases were uniformly bad as regards recurrence. When malignant growths developed outwards, metastases were slower, and prognosis was better than when they penetrated deeply.

The SECRETARY said it might be well to consider the suggestions thrown out by Coley. In cases of sarcoma he used the fluid called after his name, and he had published a number of cases which had survived for long periods without recurrence. The carcinoma was the third he had heard of in the male breast. He would give them the proportion of one to 100 in the female breast.

Mr. STOKES said he had seen two cases previous to the one before them.

Mr. HAUGHTON, in reply said he arranged the posture so that gravity would act away from the respiratory passage, which would do a good deal to prevent the inspiration of blood and septic particles.

#### I.IVERPOOL MEDICAL INSTITUTION.

SECOND CLINICAL MEETING OF THE SESSION HELD MARCH 25TH, 1909.

The President, Mr. BICKERTON, in the Chair.

DR. STOPFORD TAYLOR and Dr. R. W. MACKENNA showed the following cases:—(1) Favus affecting the thighs and legs of a steward from an emigrant ship. The scalp and other parts of the body were free. Rodent ulcer treated successfully with zinc ions. Psoriasis of the face occurring in women. Psoriasis in a man accompanied by sycosis. (5) Lupus erythematoides. (6) Syphilitic pemphigus neonatorum. (7) Dermatitis following the use of a proprietary ointment. (8) Wax casts modelled from their own cases, illustrating the cutaneous lesions of syphilis.

Dr. Logan showed a case of bi-lateral asymmetry, which he regarded as hypertrophy of the whole of the right side. The child was 15 months old, and the difference had been noticed since birth. During the last five months the right side had grown more than the left, but the head had become more symmetrical.

Dr. C. E. P. FORSYTH read a note on

THE PRESENCE OF TUBERCLE BACILLI IN THE BLOOD IN TUBERCULOSIS.

The blood of 12 patients was examined. Ten of these were undoubted cases of pulmonary tuberculosis, and in all the organism was found in the blood. The blood was drawn from a vein in the arm. In one case phagocytosis was noticed, and only in one was there any evidence of mixed infection None of the cases were rapidly progressing cases, or cases of general tuberculosis. Of the two cases in which no bacilli were found, one was probably not tubercular, and the other had physical signs of phthisis, but no bacilli in the sputum. These cases went far to confirm Rosenberger's observations for example as to the use of vaccine therapy in this disease.

Dr. HENRY CLARKE read a note on three years' experience in the use of tuberculin. His conclusions were:—(1) That tuberculin was best administered by the German intensive method, the dose being given at short intervals of one to two days, and rapidly increasing up to 1-2 c.c. of the original solution. (2) That doses given by the mouth had the same effect as when given subcutaneously. (3) That the temperature and clinical conditions were as delicate a guide to treatment as the opsonic index. (4) That new tuberculin (bacillus emulsion) was the most effective preparation. (5) That it should be prepared from human bacilli in dealing with disease produced by these bacilli. (6) To determine the variety of bacillus, he recommended Von Pirquet's cutaneous reaction. (7) He considered tuberculin a useful drug, but not a substitute for good food and fresh air.

Dr. HILL ABRAM referred to a case which he reported ten years ago, which completely recovered under treatment with tuberculin TR, subsequent experience, however, had not confirmed him in its use. He did not consider that inoculation experiments had established a vital distinction between the bovine and human varieties of tubercle bacilli. He advocated a further trial of tuberculin treatment on the German

intensive lines.

#### ULSTER MEDICAL SOCIETY.

Special Meeting Held in the Pathological Laboratory, Queen's College, Tuesday, March 30th, 1909.

The President, Mr. T. S. KIRK, in the Chair.

A LARGE number of specimens were on view from 7 till 8.30, after which hour the papers were read. Professor Milroy and Dr. J. Milroy showed microscopical preparations of the nervous system.

Professor Sinclair showed a series of surgical specimens, including many of kidney and bladder

affections.

Sir John Byers showed several ovarian tumours, including one from a patient, æt. 80, and several other gynæcological specimens.

Dr. Cecil Shaw showed a series of microscopical ections of neoplasms on the eyelids, including a very beautiful one of molluscum contagiosum.

Dr. Hicks showed three uteri successfully removed for uncontrollable hæmorrhage, showing polypoid endometritis, submucous myoma of the fundus, and carcinoma of the fundus.

Mr. Hanna showed a specimen of cancer of the larynx, and a lacerated eyeball with large foreign body.

Mr. R. J. Johnstone showed several gynæcological specimens.

Mr. Robert Campbell showed several specimens illustrating the surgery of the gall-bladder.

Professor Symmers read a paper on

ANAPHYLAXIS.

He said that a condition of hypersusceptibility to toxines had been known for some time, and had been studied lately, especially in relation to anti-diphtheritic serum. Occasionally certain unpleasant symptoms were seen after a single injection of anti-toxin, such as urticaria, cedema, or joint trouble, which came on several days after the injection. A second or third injection following in a day or two did not seem to increase the probability of such symptoms occurring; but if another dose were given after 12 days or more, it might be followed immediately by marked and even violent symptoms, such as fever, urticaria, cedema, and joint trouble. If the late dose were given after 12 days, these symptoms might be delayed for as

much as five or six days, but if the late dose were not given till the 40th day, they would be likely to appear at once. After six months, reaction still occurred, and it was not known how long the late dose might be delayed and yet produce a reaction, though it was known to be as long as five years. This condition of hyper-sensibility was apparently due to the serum, and not to the anti-toxin, and it could be produced by various other substances, as, for instance, by milk injected into the abdomen of a guinea-pig. The occurrence of this condition might explain some otherwise very puzzling phenomena occasionally observed during serum treatment, and Professor Symmers mentioned one case which occurred lately near Belfast, where a lady who had had several previous injections of antistreptococcic serum was, after an interval, given another with very alarming results. It was suggested that the serum was impure, and that some other in-fection had been introduced, but examination of the blood failed to support this theory, and probably the true explanation lay in a state of anaphylaxis having been produced. Several other cases in his experience which had shown untoward symptoms might be similarly explained.

The paper was discussed by Professor Lindsay and Drs. Gardner Robb, Houston, McKisack, and McQuitty, all of whom expressed deep interest in the views put forward in the paper. Several of the speakers had seen the cases referred to by Professor mmers, and agreed that his explanation was very

likely to be the correct one.
Dr. W. J. Wilson read a short paper on
METHODS OF ISOLATING THE TYPHOID BACILLUS.

He described the evolution of the present methods Typhoid and colon bacilli gave identical growths on nutrient agar, and the problem was to differentiate them. If lactose was added to the plate, and a little litmus, colon fermented the lactose, which turned the litmus red, but so many other organisms grew on this medium that it was not easy to find the typhoid. Conradi added a stain which prevented any but intestinal organisms growing, but it had the objection that it turned the whole plate red, and the colonies failed to show. Last year Conradi, after endless experiments, found that brilliant green and picric acid added to the medium in very minute quantities prevented the growth of any but the typhoid bacillus. Dr. Wilson had himself introduced the evaporation method, by which 4 litres of water could be evaporated under reduced pressure in 24 hours. He generally carried on the evaporation till about 10 c.c. was left, and if the water was contaminated this was found to contain large quantities of colon with only a few typhoid bacilli. In testing the method he had put 39 typhoid bacilli and 40,000 colon bacilli in 4 litres of water. In the residue the typhoid bacilli were found with ease, a result which compared favourably with the centrifugal method used by Dr. Houston, the London water expert, who added about 50 times as large a proportion of typhoid bacilli in his test. evaporation method had now been recognised as a standard method.

Dr. Wilson also read a short communication from himself and Dr. Milligan, on "Investigations on the Blood in Typhus Fever." They examined 32 cases in all, but so far their results were inconclusive, as regards finding any organism. They had satisfied themselves that Widal's test was of no use in distinguishing typhus from typhoid, as both reacted in

the same way to it.
Dr. T. Houston and Dr. S. T. IRWIN read a short paper on the

AFTER-HISTORY OF A TYPHOID CARRIER.

The history briefly was as follows:—A servant had had typhoid seven years before she came to Belfast, and from her history she seemed to have infected at least six people, of whom four were in Belfast, and under observation. All four were undoubted cases of typhoid of a mild nature. They were a man and his wife, their baby's nurse, and a hospital nurse who came to nurse them. The lady was tubercular, and had been under treatment in a sanatorium. After the attack of typhoid she did not make a very good re-covery, and tubercle was suspected. Six months later

the temperature began to rise in the evenings. urine was examined several times, and found free; then the fæces were examined, and showed typhoid infection. Two inoculations were given; the temperature came down after the first to normal, she became well, and has remained so since. Her husband made a good recovery from his attack, but the baby's nurse had never been well since her attack, suffering from headaches, and being easily tired. She has been advised to come to hospital for treatment, but has not yet done so. The hospital nurse took typhoid, and remained in poor health. On examination the bacillus of typhoid was found in abundance in her fæces. She was taken into hospital and inoculated, but the results have so far been inconclusive. The original typhoid carrier, the servant, who apparently infected the other patients, was treated in the Royal Victoria Hospital with typhoid inoculations, when her urine, which had contained the bacillus, became free, and her health good.

Dr. J. S. Dickey read a short paper on the "Surface Relations of the Apex of the Lung." The paper was based upon photographs done with a long focus lens, giving orthogonal projection of the dissections, and confirmed by measurements taken during the dis-

secting.

The meeting concluded with a vote of thanks to Professor Symmers for his hospitality to the Society, moved by Dr. Dempsey, seconded by Dr. Calwell, and passed by acclamation.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 4th, 1909.

SPOROTRICHOSIS.

Sporotrichosis, or malady of Beurmann and Gougenot, consists in subcutaneous gummata, which soften and ulcerate.

They resemble syphilis, with which they have hitherto been confounded, and so much the more as the treatment by iodides produces a speedy cure. Distinction is, however, possible, since the above-named authors made a complete study of this curious and new disease a few months ago.

From their researches they were able to divide these gummata into two clinical types—the type Dor and the

type Schenk.

The first-named is sporotrichosis, with large disseminated abscesses; the second (Schenk) resembles

the tuberculo-gumma lymphangitis of Bazin.

sporotrichosis sometimes Clinically, syphilis, sometimes tuberculosis. The gummata may not vicerate, and the persistence of the gumma, as well as the multiplicity of the abscesses, which number anywhere between five-and-thirty, and the rapid evolution of the hard gummata towards softening, facilitate the diagnosis and exclude syphilis. The distinction becomes more difficult in cases of ulceration, but here the lesions are less circular, less profound, than in syphilis. In any case, each time that no history of syphilis or tuberculosis can be discovered as to the nature of the ulceration, sporotrichosis should be suspected and treated by iodide of potassium, which acts as a specific of this malady.

BRONCHITIS AND BRONCHO-PNEUMONIA IN CHILDREN.

The treatment of bronchitis or broncho-pneumonia in children comprises three indications: render the bronchi aseptic, facilitate expectoration, and relieve the cough.

For infants, in the slight form, the patient should be kept in a warm room  $(62^\circ)$ , and the legs wrapped up in cotton wool, covered with impermeable tissue. Twice a day the thorax should be rubbed with turpentine liniment, and the room vapoured with:—

Creosote, 1 dr. Tinc. of benzoin, 2 dr. Essence of turpentine, 3 oz.

A teaspoonful to half-a-pint of boiling water.

If the case be severe, mustard poultices might be applied for two or three minutes, or just enough to redden the skin.

In children over two years of age, and more or less robust, a vomitive of hippo might be given, but not repeated, for fear of weakening the patient and pro-

voking enteritis.

In the intense form of bronchitis in infants, ipecacuanha might be prescribed in very small doses, along with balsams and antispasmodics. If diarrhea appears towards the fourth or fifth day, all treatment should be suspended, the child put on hydric treatment for a few hours, and small doses of calomel given :-

Calomel, 1 gr.

Sugar, 10 gr.
Divide into three powders. One every three hours. If the bronchitis extends to the capillaries and the lobuli—in other words, if from benign it becomes grave (broncho-pneumonia)—mustard poultices should be insisted upon, or the treatment of Preistnitz, consisting in enveloping the thorax in a compress wrung out of cold water and covered with impermeable tissue.

Diffusible stimulants are also indicated in this period :-

Acetate of ammonia, 1 dr. Syrup of ether, 3 dr. Syrup of gum, 1 oz. Water, 4 oz.

A teaspoonful every two hours.

Subcutaneous injections of camphorated oil every two or three days, says Dr. Marfau, are also indicated; up to six months a quarter of the syringe; after six months, one-half; over two years the whole syringe may be given.

In certain cases of suffocating capillary bronchitis, a mustard bath should be ordered, while septic capillary bronchitis is best treated by the cold bath, renewed three times a day.

PSORIASIS.

Cade oil, 3 oz.
Talc powder, 5 dr.
Oxide of zinc, 3 oz.
This ointment does not soil the linen, while, by reason of its adhesive properties, it renders application unnecessary for more than two days.

#### GERMANY.

Berlin, April 4th, 1000.

AT the Medizinische Gesellschaft, Hr. Bier introduced the subject of

LOCAL ANÆSTHESIA FROM THE VEINS. He described the procedure brought forward at last year's Surgical Congress, and which since that time had been subjected to many tests at operations, at which he had further elaborated the method. It was only applicable to the extremities, as it was a necessary part of the procedure that the part should be deprived of its blood. After this had been done, a part of the limb was constricted between two elastic bandages, under Schleich's anæsthesia the vein was sought (by preference the saphena vein or the cephalic) and a per cent. solution of novocain injected, so cc.m. for the arm, 80 cc.m. for the leg. For children a correspondingly smaller quantity was used. poisonous action need be feared; for greater safety, however, before the bandage was finally taken off, it might be lifted for a few seconds, and replaced; the saline solution, before final removal of the elastic bandage. Squeezing the novocain out of the wound did no harm, but it was unnecessary. The part lying between the two ligatures became anæsthetised after. 6 to 8 minutes, and in another 6 to 8 minutes motor action was abolished. The local anæsthesia was not limited to the terminals of the nerves, the nerve trunks also became completely insensible. In this way the severest operations could be performed on the extremities without the slightest pain being felt. The speaker. had performed resections of the large joints, removals of necroses, and the like many times. In 134 operations the anæsthesia had only failed in five cases.

This form of anæsthesia was indicated in operations on the extremities, but contra-indicated in the gangrenes of old age and diabetes.

After removal of the ligatures the motor paralysis disappeared at once, and the sensory after a few minutes; that was an objection, as it presupposed that the operation must be completely ended, even to the putting in of the stitches, before the blood was allowed to return to the part, the arrest of hæmorrhage must, therefore, be most exact, and even the smallest vessels be ligatured, and this was not always to be done with certainty and ease. All attempts to lengthen the period of the anæsthesia after removal of the ligatures, as by the injection of other substances, such as adrenalin, acoin, etc., had hitherto failed. The method was likely to limit the range of lumbar

At the meeting of the 17th ult., Hr. Thumin discussed the

· RELATION BETWEEN THE OVARIES AND THE

PINEAL GLAND.

In a young girl the menses failed to appear, and the symptoms of acromegaly gradually developed. During the course of this there were signs of nephritis, but these passed away; this the speaker took to be due to intoxication. Then the voice changed, it became deeper, and the singing voice was lost; by the laryngoscope the vocal cords were seen to be lengthened, a result of growth of the larynx. Whilst hypophysis tablets were being given the condition became worse, but afterwards it came to a standstill. By Röntgen illumination a tumour was seen at the hypophysis; there was atrophy of the uterus and ovaries. He considered that there was a connection between the two in the case.

Hr. Rosin made some short remarks on some

TYPHOID FEVER.

He had seen three atypical cases during the winter, such as had been described by Litten in 1879, and seen more frequently later by Ewald in Berlin, and Schlesinger in Vienna. The number of cases Schlesinger in Vienna. announced in Berlin had been rather larger than in the previous year, especially in the western part of the city. The cases were mostly amongst the better classes, and the number in hospitals was not increased. The water was not the cause, as the disease occurred in the most varied parts, with the water supply from equally varied sources. Milk and other articles of food had to be considered, caviare, perhaps, in the first line.

Hr. Fürbringer had seen similar atypical cases. The differential diagnosis between these and influenza was very difficult, and this point was not sufficiently noticed in literature.

Hr. Wolff-Eisner doubted whether cases had been more numerous than usual; neither did he think that atypical cases were more numerous in the city than in the country; in the latter parts the means of diagnosis were absent. As regarded caviare as a bearer of infection, it had been ascertained that in salted caviare the bacilli did not remain long alive, only unsalted caviare therefore came into consideration.

## AUSTRIA. |Vienna, April 4th, 1909. CHONDRO-DYSTROPHIC DWARF.

KATHOLICKY, at the Gesellschaft der Aerzte, presented a male, æt. 31, a confectioner, and measuring 120 centimetres, or 47.2 inches. The inhibition of growth seems to be confined to the extremities, which were very little bent in the lower, and not at all in the upper, the latter reaching to the trochanter tuberosity with the point of the finger. The gait is of a waddling character; intelligence good; genital organs perfect; but there is a hydocephalic cranium, measuring 50 centimetres, or 19.67 inches in circumference, set on a long, small neck, with the nose deeply depressed. The peculiarity of this case was its appearance in a family with a good history and no record where a blemish could be transmitted. He exhibited other two of the same character, but with a

different record.

Gluesner next brought forward a father, æt. 56, and son, æt. 20, who measured 101 centimetres and 108 centimetres respectively. Both of these had the characteristic symptoms of chondro-dystrophia—viz., large head, saddle nose, broad pelvis, and short extremities. There were also enlargement at the epiphyseal union, lordosis in the lumbar region, and kyphosis in the dorsal; the elder had the "main à trident" and subluxation of the femur. There was no bending of the long bones, the thyroid normal and functionally active, while the genitals were well developed and the intelligence clear, which confirmed the opinion that the cases were genuine chrondro-dystrophic in nature, that produced the dwarfish condition.

#### PHLEGMON OF PENIS.

As interesting contributions to surgery, Albrecht exhibited three cases he had successfully operated on by making free subcutaneous incisions. The first had been caused by a band tied tightly round the member. The second had been the result of phimosis, or rather para-phimosis, which led to balano-posthitis ulcerosa, and subsequently caused an abscess to form, that burst into the urethra, producing five fistulous openings, from which the urine poured. The third case was the result of an injury that occurred five years ago, with a nail that caught him, tearing the urethra from behind forwards, and damaging the organ so much in the middle that a mere bridge connected the injured part. The patient, before coming to hospital, took the scissors and cut this bridge, mutilating the organ and in-creasing the phlegmon. All of these cases were freely incised and disinfected, with the best results.

TETANY.

Spieler showed a girl, æt. 10, who had suffered for several years with recurring tetany. She had the typical cloudy lens and hypoplasia of the teeth. According to the family history, she was brought up on the breast, and learned to walk between the ninth and tenth month. She had always prominent tubera frontalis, but no special sign of rachitis. Her mind and body seemed always to develop with her age, and nothing special or unusual could be noted in her history. The tria, or Chvostek, Trousseau, and Erb's phenomena were strongly marked—i.e., pressure on the motor nerves, blood-vessels, and eccentric electric stimuli were all exalted. Gently striking the facial muscles produced easily Escherich's-Buckle phenomenon or contraction of the musculus orbicularis oris, This could be induced by striking either the upper or lower lip. If the arm were tied with a cord, or pressure on the plexus brachialis applied, the contractions were immediately induced. If the electric stimuli or galvanic irritation were applied on the left side of the head near the eye, cloudy rays could be seen running from the periphery of the lens towards the centre, while in the right lens a number of fine punctiform specks, varying in size, will be seen, as Peters has described, to radiate from the margin. In addition to these symptoms, it is interesting to note the trophic dis-turbance in the teeth, which has produced a distinct hypoplasia, particularly in the upper and lower in-cisors and pre-molars. In addition to these symptoms of the teeth and lens which the mother had observed, another important observation was made with respect to the hair, which was split up at the ends into points or trichorrhexis, apparently depending upon the disturbed trophic ectodermal surface. All these morbid changes seem to have some connection in tetany with the function of the epithelial bodies in the thyroid. The nails of the patient were remarkably healthy and perfectly normal, neither breaking, cracking, or tearing. In summing up the peculiarities of this case, he said that for eight years a chronic recurrence of tetany had been going on in this girl, which, he considered, had been directly transmitted from infancy and carried on to the puerile state, when the real distinguishing trophic disturbance in the nerves, lens, teeth and hair were physiologically developed, and, according to Pineles and Erdheim, are closely connected with the function of the epithelial bodies. Hence the disease may be correctly described as being of a parathyreopriva pathogenesis which has produced the tetany noxa.

#### HUNGARY.

Budapest, April 4th, 1909. At the recent meeting of the Hospital Association, Dr. F. Wittmann read a paper on INFANT FEEDING.

He discussed the embarrassments of infant feeding when breast milk is not available, and the unsatis-factory results of the common practice of diluting cow's milk with water in such cases. He summarised practically as follows: Cases of difficult feeding in infancy are:—(1) Those of fat indigestion; (2) those of sugar indigestion; (3) those of proteid indigestion. Each of these may occur alone, or in combination with the others. Proteid indigestion is the most common, but fat indigestion is also frequent. Each must be treated individually, the form of indigestion present must be ascertained, if possible, and appropriate measures adopted. The treatment is almost exclu-sively dietary; the fats and sugar can be regulated by varying the amounts of cream and sugar in the food. The composition of cow's milk, with its high caseinogen, must be cut down or eliminated, if need be, and the lactalbumen retained. This twofold object is attained by feeding whey, as advised by F. S. Churchill (America). In conclusion, he suggested the desirability of careful study of artificially fed infants and publication of the results.

THE RELATION OF TUBERCULOSIS TO PREGNANCY.

Dr. Popovics said that, according to the statistics, pregnancy tends to increase the susceptibility of the individual to tuberculosis. Cases occurring during the pregnant state are severe, with a marked tendency to laryngeal involvement. The pregnancy is, as a rule, not interrupted, but it is not uncommon for an advanced case of phthisis to be delivered at full term, the child dying in a few days, and the mother in a few days or weeks. Dr. Popovics has been led to consider that tuberculosis in itself predisposes pregnancy. Similar assertion has been made also by foreign doctors, as, for instance, by Malsbary, of New York. In view of the special susceptibility, pregnant women should be protected from tuberculosis, as from other infectious diseases. The habit prevalent among pregnant women of going into retirement should not be tolerated if such retirement precludes hygienic surroundings, pure air, and sunlight. Fresh air, exercise, and proper diet, combined with the use of tuberculin and creosote, constitute the essentials of treatment. The desirability of artificial interruptions of pregnancy is problematic in these cases, especially when the objective symptoms do not show progression of the disease. As far as pulmonary tuberculosis is concerned, the operation is of no especial benefit.

RADIOTHERAPY IN TRACHOMA. Dr. Pollak exhibited seven cases of trachoma and follicular conjunctivitis treated successfully by radium, the action of which he defined as "cito, tuto et jucunde." He finds a theoretical basis for the success obtained, inasmuch as it is assured by several investigators that the beneficial action of radium is due to its power to decompose the lecithin which forms a substantial element of these growths. As the granula-tions of trachoma also contain a certain percentage of this substance, the effect thereon of radium becomes intelligible. The lecturer picked out seven trachomatous cases of a most pronounced character. amount of radium used was at first 1 mg., and later 10 mg.; time of exposure, 5 to 10 minutes. The tube 10 mg.; time of exposure, 5 to 10 minutes. containing the radium was simply applied over the area treated, and slowly moved about without touching the surface. The results were really astonishing. Five of the seven eyes were entirely cured; the other two are in a fair way of becoming so. The absorption of the granules was not accompanied by any untoward The number of sittings varied from 8 to 14. Dr. Pollak firmly believes that even in cases where the granules are extensive, good results can be obtained with ladium, and that the treatment, when properly conducted, is perfectly harmless.

Dr. Révés lectured on the
TREATMENT OF EPILEPSY.

He stated that many cases of epilepsy are not benefited much by the usual bromide therapy, since, in

the place of an occasional attack of convulsions, they will now suffer from chronic bromism, which renders them absolutely unfit for any mental work. If the patient is seen after the first attack, an attempt should be made to prevent recurrence by hygienic measures alone. This is also indicated in those cases where the attacks recur not oftener than every two to three months, and frequently the proper diet, with attention to the bowels and suitable occupation and surroundings, will mean a permanent cure. Unfortunately, the bromides cannot be replaced in severe cases, and even bromipin is not always well tolerated. In certain instances, atropine, either alone or in combination with oxide of zinc, will accomplish much. The preparations of valerian will also occasionally ward off an attack, but no permanent results have attended its use.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

EDINBURGH UNIVERSITY SPRING GRADUATION CEREMONIAL.—The graduation ceremonial, which took place on April 2nd, was notable in that for the first time the Sex Faculties of the University were simultaneously represented; the granting of medical degrees in the spring-time is a novelty, depending on the recent rearrangement of the professional examinations, and is, therefore, likely to be repeated in future years. For the first time in the history of the University two ladies received the degree of Bachelor of Laws. The list of recipient of Honorary Degrees was unusually large: it included the names of Professor Crum Brown, Mr. J. M. Barrie, Mr. J. G. Bartholomew, Lord Dundas,. Sir Alfred Keogh, Professor Kronecker, and others. In introducing the recipients of the degree of LL.D., Sir Ludovic Grant described the work of each in one of his usual felicitous speeches—he paid a tribute to the catholicity of Professor Crum Brown's interests, saying that on him had fallen the mantle of the first Professor of Chemistry in the University, who was of such versatility that he was simultaneously appointed Professor of Hebrew and Chemistry. The appropriateness of the remark will be apparent to all who know Professor Crum Brown's accomplishments as an Orientalist. To Sir Alfred Keogh, Sir Ludovic paid the compliment of ascribing to his organising genius. the improved status of Army doctors and the betterment of their relations with the combatant branch of the Service, and also the arrangements which are being made whereby the Territorial forces will enjoy the services of the leading physicians and surgeons throughout the country. Professor Kronecker has just throughout the country. Professor Kronecker has just completed his 70th year, and in congratulating him Sir Ludovic Grant asked his acceptance of the degree Sir Ludovic Grant asked his acceptance of the degree as a birthday offering. After the ordinary degrees had been conferred, the new graduates were addressed by Professor Kirkpatrick, who urged that the teaching of History in the University required amplification by the foundation of Chairs of Greek and Roman History and of Constitutional History. Heales claimed for Modern Languages that they should also claimed for Modern Languages that they should once and for all receive recognition as fully equal to Latin and Greek, and spoke of the reforms needed in the Faculty of Law, whereby the B.L. degree, instead of being limited to Scottish students by the compulsory inclusion of Scots Law and Conveyancing, might become attractive to English, Indian, and Colonial students.

TREASURY COMMITTEE ON SCOTTISH UNIVERSITIES .-The committee which was promised some months ago to consider the claims of the Universities for additional State assistance has now been appointed and consists of the following members, with Lord Elginas chairman:—Miss Haldane, Sir Kenelm Digby, Principal Sir Harry Reichel, Mr. C. M. Douglas, Professor A. R. Forsyth, D.Sc., and Professor Sims Woodlead. Miss Haldane is a sister of the Missier for head. Miss Haldane is a sister of the Minister for War, and is well known in Edinburgh for her interest in educational matters. Professor Woodhead and Mr.

Douglas are connected with Edinburgh, the latter being a son of the late Dr. Halliday Douglas. Sir Harry Reichel is now Principal of Bangor University; he wrote the Moseley Commission Report on Education in 1904. Professor Forsyth is a native of Glasgow, and has been the Sadlerian Professor of Pure Mathematics since 1895.

Hon. Sydney Holland on Edinburgh Poorhouses. The Scotsman of April 1st contained a letter from the Hon. S. Holland adversely criticising the administration of the Edinburgh poorhouses, particularly as regards their hospital management. He was inspired, he says, to come and see for himself how things were done, from a study of Mrs. Sydney Webb's report (the minority report of the Poor-law Commission), and found what she alleged—impossible and intolerable as it seemed—was all true. The gist of his complaint against the Poor-house (Craiglockhart is that particularly specified) is that for an institution with over 800 inmates, 280 of whom are in the hospital, there is only one lady resident medical officer, who supervises the wards, operates when necessary, attends the confinements, performs post-mortems, and examines all persons admitted. The nursing is also inadequate; no proper sterilising apparatus is supplied to the theatre; the only other assistance afforded is that of a consulting medical officer who visits twice a week. An attack of this kind, made by a man occupying so responsible a position as Mr. Holland, cannot, of course, pass unanswered—indeed, much of his criticism appears to be justified. At the same time, it must be remembered that the class of patient admitted to the Poor law hospitals in Scotland differs consider. to the Poor-law hospitals in Scotland differs considerably from that admitted to English infirmaries. Most of the cases here are of chronic disease; sudden cases of acute illness or emergency are seldom, if ever, admitted to Craiglockhart. Again, it is certainly not uncommon for the staff of the Poor-house to obtain the assistance of a surgical specialist when serious operations have to be performed; and, as a matter of practice, the consulting medical officers visit more frequently than the statutory twice weekly. One serious part of Mr. Holland's allegation is that among the duties required of the lady medical officer is that of superintending a ward for male venereal disease. Some years ago, when women were first appointed to these posts, an arrangement was made whereby this class of case was treated only at Craiglockhart, then under the charge of a male resident surgeon. Apparently, however, with the lapse of time this arrangement was forgotten, and though the venereal cases were still drafted to Craiglockhart, a woman was appointed to the house-surgeonship. Apart from the slight resentment which Mr. Holland's rather gratuitous attack may cause, his criticisms, in so far as they are just, will doubtless do good by drawing attention to what defects exist in the management of the Poor-house hospitals. It is only right to add that Mr. Holland most amply bears witness to the efficiency of the lady medical officer—the burden on her, he considers, is not one which can fairly be borne.

#### BELFAST

BELFAST OPHTHALMIC HOSPITAL.—The annual meeting of this hospital was held last week. Mr. Frank Workman presiding. The medical staff report was read by Dr. Cecil Shaw, and spoken to by Dr. Walton Browne. It showed increased work in every department. The total number of patients seen in the extern department was 2,315, and the total number of visits paid was 7,767. An urgent appeal was made for funds to alter and enlarge the extern department at an estimated cost of about from and also for increased mated cost of about £500, and also for increased annual subscriptions. For many years the sum charged for patients sent up from country Unions for special treatment was only 7s. per week, which was quite insufficient to pay for them, and the charge has now been altered to 15s. per week, which it is understood is that paid to most Dublin hospitals where Union patients are sent. The average cost of patients in the hospital

per bed occupied is about 21s, per week.

ROYAL VICTORIA HOSPITAL.—The annual meeting of this hospital was held last week, and as in the smaller

hospital the gist of the business was an appeal for more funds, four wards being empty for want of money to maintain them at work. The treasurer said that he found that the cost per bed in the Royal Hospital came out 48 per cent. cheaper than the average of twelve principal hospitals in London, and 17 per cent. cheaper than the average of nineteen chief English and Scotch provincial hospitals. The medical staff report stated that the number of intern patients treated during the year was 1,375 medical and 1,961 surgical. There were 1,427 operations, with a mortality of 4.62 per cent. In the extern department over 30,000 new cases were treated, and 4,718 teeth were extracted. Mr. R. J. Johnstone, in moving the adoption of this report, appealed for £5,000 or £10,000 for a new X-ray department, which he suggested some wealthy person might give to them.

PUBLIC HEALTH.—During last month the death-rate in Belfast was only 20.3, as compared with 27.3 during the same period last year, while the rate from zymotic disease was only .6, as compared with 2.8. For four weeks there was not a single case of typhoid fever—probably a unique event in the history of Bel-

fast for many years past.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents, ]

#### "DOCTORS AND MIDWIVES."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The last communication from Dr. Griffith is suggestive. A few thoughts occurred to me while reading it. I think that some of our recently qualified colleagues would be eternally grateful to Dr. Griffith if he would direct them to some of these isolated spots where it would be difficult or impossible to obtain the assistance of a colleague in the event of an emergency. The difficulty of most of us is to prevent our colleagues assisting us against our wish. Personally, I should prefer to be sent for by a nurse unnecessarily, rather than when damage is done; which damage I am expected to repair, with the knowledge that I shall get the credit of having done the mischief.

Just a word about the administration of chloroform. If we allow a nurse to give an anæsthetic we are guilty of "covering." We should be more guilty morally than if we employed an unqualified assistant to perform the same duty, who had completed his curriculum, but who had not as yet passed his final. How we rejoiced when we got rid of the unqualified assistant, and yet if Dr. Griffith's dreams came true we should be merely replacing one abuse by another,

and a greater one.

Then we must remember that the operator is responsible for the anæsthetist, and in the event of a patient dying under an anæsthetic administered by a nurse, I fear that the medical man would not emerge from the inquest without censure.

I am, Sir, yours truly, S. J. Ross.

Monkhams, Bedford, April 3rd, 1909.

#### THE DECLINING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-Mr. Clement H. Sers seems to overlook many vital facts. The British Empire, including India. holds altogether not more than 60,000,000 of people of European blood. Our colonies, together as big as three Europes, with the finest climates on the earth's surface, and with scarcely touched, inexhaustible resources, are crying out for people. With a properly organised Imperial system of emigration they could take and absorb our normal increase for hundreds of years. If we do not fill these lands ourselves, they will in the end—an end not far off—virtually cease to be British, through swamping by alien peoples, if they are not taken by force by some more virile race. If the present decline in the birth-rate continues, we shall

presently have no surplus to send away. Mr. Sers seems to think that our present mass of wastrels and unemployables represents an irreducible minimum; it is diminishing, and will diminish yearly with greater rapidity as the nation adopts the measures of social reform which all parties in the State are now agreed upon. The number of physically unfit will diminish with improving national sanitation, with the control of tuberculosis; and the prevention of rickets, and all the minor maladies which lead to permanent unfitness of greater or less degree. Reform of the Poor-law, the Children's Bill, with improving education, and such-like measures, will improve the morale of the masses. The prime importance of social reform is accepted by statesmen, and will be worked for with increasing ardour, and there is good reason to suppose that the number of our december with that the number of our degenerates will gradually sink to a negligible quantity. Next, Mr. Sers forgets that Germany has at home 65,000,000 of people, many more millions than we have of whites in our entire Empire, and that she is increasing at the rate of a million a year. Then he forgets that France, which has carried the population question to the logical conclusion of the anti-patriotic egoist, her married citizens all refusing to make the sacrifice needed in rearing more than two children, now lies at the mercy of Germany, having only 39,000,000. Every single year for the last thirty years Germany, through her increase, has become a full army corps stronger than France. If we follow France's example, we shall be as a world power in a similar position within very few years. The French are a dying race; their wealth increases while their men decay. Their decadence is manifest in moral as well as physical phenomena; it forms the most serious as well as most interesting forms the most serious as well as most interesting study in contemporary history, an object-lesson which, it is to be hoped, may not be obscured completely by the prevailing cult of the entente cordiale.

I am, Sir, yours truly,

A STUDENT OF SOCIOLOGY.

March 31st, 1909.

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#### **OBITUARY.**

PROFESSOR ARTHUR GAMGEE, M.D., LL.D.ED., F.R.S., F.R.C.P.LOND. AND ED.

WE regret to announce that Professor Arthur Gamgee died in Paris on Monday, March 20th, in his 68th year. He was Emeritus Professor of Physiology in the Victoria University, and had been Assistant Physician to St. George's Hospital, London.

Elected a Fellow of the Royal Society at a very early age, his life was devoted to special research work in problems of physiological chemistry; and he held, from time to time, a number of physiological posts in the University of Edinburgh, in Owens College, and in the Royal Institution of Great Britain. He added largely to our knowledge of the chemistry of the blood and of its colouring matter; and much of his work was and of its colouring matter; and much of his work was conducted in the physiological laboratories of Germany, France, and Switzerland. Apart from a large number of papers, he will be chiefly remembered for his "Text-book of Physiological Chemistry of the Animal Body," in which much original research was incorporated, and which has been translated into French and German.

Dr. Gamgee was a fine classical scholar and a good aguist. His unexpected death was due to pneumonia, which developed after an attack of influenza.

#### JAMES HARDIE, M.D.Ed., F.R.C.S.

We regret to announce the death of Mr. James We regret to announce the death of Mr. James Hardie, of Manchester. Born at Tyinghame, in East Lothian, in 1857 he entered the University of Edinburgh as a medical student, and came under the influence of the great Syme and the still greater Lister. The opportunity of becoming a surgeon, which he much desired, came to him when he was made Surgeon to the, at that time, small Clinical Hospital for Diseases of Women and Children at Park Place, Cheetham, now the Northern Hospital. This success

was followed by his appointment as surgeon to the Manchester Township Hospital. His excellent work in these two offices prepared the way for his election to the position of Honorary Assistant Surgeon to the Manchester Royal Infirmary. This was in 1876. On the retirement of Mr. Edward Lund, in 1882, he became full Surgeon to the Institution, which position he occupied until 1901, when he became Consulting Surgeon. As a surgeon Mr. Hardie devoted himself especially to orthopædics. In such cases he was distinguished by the originality and ingenuity of his operations, and the dexterity and success with which he carried them out. For some years he was a member of the Council of the Royal College of Surgeons, a position which he filled with distinction.

#### DAVID PIERCE FOULKES, M.B., C.M.ED.

WE regret to record the death of Dr. D. P. Foulkes, of Conway, which took place at Swansea, following an attack of rheumatic fever. Some six months ago Dr. Foulkes accepted an appointment at the Swansea Hospital, where his fatal illness began, but he had not been in good health for some years. The son of Mr. Thomas Foulkes, of Conway, and formerly of Blaenau Festiniog, he took his degrees of Bachelor of Medicine and Master in Surgery at the Edinburgh University in 1893, and for some years afterwards practised at Conway.

AUGUSTUS HENRY COLLET, B.A., M.R.C.S. WE regret to announce the death of Dr. Augustus Henry Collet, which occurred at Worthing. Dr. Collet, who was within a few days of his 65th birthday, was a native of Worthing, and a member of a highly respected local family. He was prominently identified with local movements, and held some imidentified with local movements, and field some important public positions. He was appointed a member of the honorary medical staff of the Worthing Hospital on December 29th, 1871, following Dr. A. Sharpe, who, in 1864, had succeeded Dr. H. J. Collet. In 1887 the retirement of Mr. W. J. Harris from the medical staff, after nearly 24 years' service, placed Dr. A. H. Collet in the position of Senior Medical Officer, which he held until the last. During the past year he was elected Chairman of the Committee of Manager. was elected Chairman of the Committee of Management. Dr. Collet had by far the longest record of service for the Hospital, having been connected with the institution for 37 years.

#### SAMUEL CLEWIN GRIFFITH, M.D.ST.AND., M.R.C.S.ENG.

WE regret to announce the death, in his 80th year, of Dr. Clewin Griffith, at his house in Woburn Square, London, on March 15th, after a long illness. His father many years ago was a well-known practitioner in Gower Street, and reached the advanced age of 90 years.

The son was for some time in practice in Finsbury Square, and a few years ago filled the office of Master of the Society of Apothecaries. A portrait of his father, who was also a Master of the Society, may be seen at Apothecaries Hall. Dr. Clewin Griffith and his wife, who died several years ago, were forward in a variety of useful and philanthropic works, and their loss will be much felt.

Deceased was educated medically at St. Bartholomew's, University College and Paris. He was M.D. of St Andrew's, M.R.C.S.Eng. (1846), and I.S.A. (1847).

#### MATTHEW DICKSON, M.D.ABER.

WE regret to announce the death of Dr. Matthew Dickson, of Liverpool. Born in Rhynie, Banffshire, in 1842, he was educated at the Aberdeen Grammar School, Marischal College, and Aberdeen University. In his early medical life he was Surgeon to an Arctic expedition, and later two years at the Liverpool Medical Mission. He was also for seven years Medical Missionary in Formosa in connection with the Presbyterian Church of England. Being an ardent naturalist, in many of his journeys he carefully studied the flora, fauna, and ethnology, particularly of Formosa, sending home considerable collections. He discovered several new species of shells, one of which is named after him—Melania Dicksoni.

## EDGAR OSWALD HOPWOOD, B.A., M.D.Oxon., D.P.H.

WE regret to record the death, at his residence at Manchester, of Dr. Edgar Oswald Hopwood, who was well-known in connection with the work of the London Fever Hospital. Of modest and reserved temperament, Dr. Hopwood made himself little known in the medical world, but those associated with him realised that he was one of the soundest authorities on fever in the country. His judgment in diagnosis was particularly good, but he was content to pass his life in the quiet of hospital residence, without seeking to achieve fame outside.

#### REVIEWS OF BOOKS.

PRIESTS OF PROGRESS. (a)

This book is described in the advertisement which accompanies it as "a work of enthralling interest, which sets forth the case against vivisection with a power, vividness and realism which is likely to win many converts to the anti-vivisection cause." It is, we suppose, on account of the views which the author puts forward, and not on account of the story, that we have been asked to review the book, and we shall in consequence deal with it from that point of view The author in his preface states that the methods described are real methods recounted scientific journals, but here attributed to characters essentially and entirely fictitious." Furthermore, we have in an appendix a list of the authorities "for the actual theories and practices attributed to those characters." In this way the author has given a semblance of reality to his story, and will, we have no doubt, create a feeling of belief in the minds of some of his readers in the truth of his inferences and in the sincerity of his arguments. As an example of this we may cite an incident, perhaps the most striking in the book, in which an operation is described as having taken place in a London hospital, and of which the author was informed by a doctor whose friend, a surgeon, witnessed it." The patient, S. J., a young woman, was admitted for treatment of what the doctor described "as ulceration of the skin, just a surface thing." The operation performed, however, by a leading London surgeon, and apparently without the consent of the patient, was excision of the superior maxilla. Furthermore, we are led to believe that the reason for doing this operation was not the diseased condition of the patient, but merely that the surgeon might demonstrate to the class his skill in the performance of a difficult and dangerous operation. That such an incident as this ever took place in any hospital we beg leave to doubt, and further we are convinced that any-one who believed that it did, and had evidence in support of that belief, would be guilty of a grave moral offence in suppressing any of that evidence. If our author has evidence in support of the truth and reality of this incident, as he would lead us to believe he has, his suppression of that evidence is so damaging to his moral character that his views on other questions of morals can have little weight. On the other hand, if he is not in possession of this evidence the way he has introduced the incident into his book is, to say the least of it, disingenuous.

We are, however, inclined to join issue with the supporters of the anti-vivisection movement on the fundamental principle which underlies their position. This principle, stated broadly, is that the infliction of pain when not for the good of the person or animal on which it is inflicted, is wrong, and may be considered as cruelty. If this position be once granted, all experiments on the lower animals are, of course, unjustifiable. The word "cruelty" has at least two meanings which should be carefully distinguished—

(a) "Priests of Progress." By G. Colmore. 8vo. Pp. 392. London: Stanley Paul and Co. 1908.

(1) a disposition to inflict suffering, delight in or indifference to the pain or misery of others; and (2) severity of pain or excessive suffering. Experiments on animals may involve cruelty in the latter sense without the necessary attribution of moral culpability to the experimenter. But this distinction is not kept in view by the anti-vivisectionist. An experiment involves pain, perhaps severe pain; it is at once spoken of as cruel, and the experimenter stigmatised. But what grounds are there for maintaining that the infliction of pain is morally wrong? Throughout the entire animal kingdom, from the lowest organism to the highest, we see that organism lives, and can only live, by preying on others, and thus inflicting pain. Man obtains a large part of his food by killing other animals, and the ultimate sanction of the law which protects the community is the right to inflict pain on those who transgress the law. The penalty of the law is for the protection of the community, and not for the good of the individual punished. It seems idle, then, to argue that the infliction of pain is in itself evil. But the infliction of pain may readily become an evil if the motive of the action is an evil one, and in this sense our author is right when he says that vivisectors maintain that the end justifies the means, but he is wrong if he thinks that in this sense the statement is the opprobrium of ethics. The means are here moral or immoral, according to whether the motive is good or bad.

It will be urged that this argument would as well justify experiments on human beings as on the lower animals, and so it would were human beings merely animals. But since human beings are believed to be something more than animals, the community has deprived the individual of the liberty of treating a human being as he would treat an animal. When experiments are tried on a human being, it is either because the individual has given consent, or because it is believed that the experiment will result in benefit to that individual.

It seems unnecessary to follow our author through all his various arguments, believing, as we do, that the fundamental basis of them is false. There is one, however, which we should like to mention—namely, the objection to the use of therapeutic agents derived from animals, which practice our author considers—and rightly—as one of the results of vivisection. This practice is described as the injection into people of "animal nastiness." We fail to see, if an animal's flesh may be used for food, why its serum should not be used to cure disease, and, if to cure, why not to prevent.

We have devoted our entire consideration to the views expressed in the book, because with them, and not with the story, we, as a medical journal, are concerned, but we may say that, apart from the sceptical views, the story is of little interest, and will not probably attract many readers.

#### THE KNEE-JOINT. (a)

THIS book deserves the attention that its distinguished authorship cannot fail to attract. It is an excellent little monograph, written in the language of an experienced teacher for the benefit of "those who have as yet had less experience than the writer."

While it is by no means an exhaustive treatise on the knee-joint and its ailments, we can commend it to students and practitioners possessing ordinary acumen, as it is likely to prove very helpful to them in familiarising themselves with the crucial points concerned in the differential diagnosis of diseases and injuries connected with this joint. Sir William Bennett's wide clinical and anatomical experience has led him to the belief that unilateral hypermobility is suggestive either of disease or some physical defect, and that the integrity of the joint is largely dependent upon the ilio-tibial band. In treating acute effusions into the knee-joint, the author is opposed to immobilisation and cold applications. He relies on the hyperæmic treatment and hot compresses. As soon as

(a) "Injuries and Diseases of the Knee-Joint. Considered from the Cliuical Aspect." By Sir William Bennett, K.C.V.O., F.R.C.S. With thirty-four illustrations. London: James Nisbet and Co. 1909.

the tension shows signs of diminishing, he adopts gentle movement and massage. The chapters on painless effusion, pain in and about the knee, and recurring effusion after injury, will repay perusal. Chapters VIII. and IX. are devoted to that all-important subject, "Internal Derangements of the Knee." The author supports his opinions by the records of numerous cases that have come under his records of numerous cases that have come under his observation both in private practice and at St. George's Hospital. He deprecates operations in the presence of fluid in the joint, and recommends passive or voluntary movement at the end of a week. In ordinary cases, he says, patients should be walking in a fortnight. He contrasts this modus operandi with that recommended in the latest American work on surgery edited by Keen, viz. —"Fixation for two or three weeks should follow, after which massage and passive manipulations are begun." Early tuberculous disease and induced hyperæmia in the treatment of affections of the knee-joint are well sketched in the two concluding chapters. The X-ray photographs are good.

MANUAL OF BACTERIOLOGY. (a) THE preparation of the third edition of this deservedly famous book has been undertaken with conscientiousness. The text has been brought well up to date; practically all the recent research of any importance being prepared for the reader's assimilation. Many new illustrations add to the helpfulness of the book, diagrams illustrating Ehrlich's side-chain theory being included. Among the additions, the portions dealing with vaccines, opsonic indices, and recently discovered protozoa may especially be commended to the reader's attention.

The chapter on the "Examination of Water" is

thoroughly up-to-date, and has been rewritten in a manner calculated to be of the greatest service to the student. Incidentally, we notice that the author, bearing in mind a lament at the beginning of the book about the chaotic condition of bacteriological nomenclature, is precise as to his terminology; hence we have "ptomine," "B. Welchi," etc. Errors are almost absent, the only ones we have noted being—"mercuric chloride" being substituted for "carbolic acid" on page 605, and the coefficient of mercuric chloride being given as 400. The latter figure refers to tests in which no attempt was made to preclude antiseptic action in the sub-cultures—when this was done Walker showed that the carbolic acid coefficient dropped to 20. Also, when discussing the results of anti-typhoid inoculation, "inoculated" is obviously meant for "uninoculated" (page 343, line 20).

THE PRACTICAL MEDICAL SERIES. (b)
This is the second medical volume of this series for the year 1908, the first of which was reviewed in our columns some months ago, and we are glad to say that the present volume maintains the high opinion that we then expressed of the series. The recent work on the various diseases with which the volume deals is admirably epitomised, and references given to the original papers. Very considerable space is given to typhoid fever and to diseases of the stomach, indeed, more than half of the book is taken up with these important subjects, the work on which is gone into most fully. We cannot say that we have detected any omissions of importance, and the admirable index, both of subjects and authors, makes the task of searching for any paper an easy one. The present volume is marked No. VI., being the sixth of the series for 1908, the former medical volume of the year being No. I. We would suggest to the publishers that as many medical men will not require the entire series, that the volumes dealing with same subjects should be marked consecutively. A practitioner nowadays can hardly afford to be without some such book, and of its kind it, the present volume, is one of the best we have seen.

DICTIONARY OF MEDICAL TREATMENT. (a) THE object of this little book is to present to the practitioner a definite course of treatment for any disease which is commonly seen in medical practice. We are not sure that such a work is suited to the requirements of students, who are more in need of studying principles than methods of treatment. To the junior practitioner, however, such a work presents many advantages, since it helps him in the applica-tion of those principles at a time when as yet his methods have not been, as it were, crystallised by experience. The methods which are here taught are excellent, a due proportion being maintained between those of a general nature and the prescription of drugs. There is also an admirable description of the newer methods, including vaccine therapy. Of this the author has evidently had a good deal of experience, and we are glad to hear him speak so highly as he does of the method. We can heartily recommend the perusal of this book to junior practitioners, and believe that many who are no longer junior will find much to interest them in it.

FOOD MICROSCOPY. (b)

Few medical men realise the deep debt of gratitude the world owes to the late Dr. A. H. Hassall for his researches on the microscopical structures of food materials. His labours placed the detection of adulteration on a sound scientific basis, and very considerably restricted the activities of the food sophisticator. Since the appearance of Hassall's work, "Food: Its Adulteration and the Methods for their Detection," thirty-two years ago, a certain amount of been done, and a revision and additions were necessary to make the work up-to-date. For this task it would have been difficult to find a more suitable editor than Mr. Clayton, who has himself enriched our knowledge of the subject in most valuable ways, and who, as the personal friend of Hassall, can be depended on to render this work a worthy successor to the original one. It is obvious that this revision has been no light work, but it has been accomplished in a manner that Hassall himself, were he still with us, would be the first to appreciate, and to say this is perhaps the greatest compliment we can tender to the author. A very large amount of new matter has been incorporated, and the volume will be found indispensable to the Medical Officer of Health, to the candidate for State Medicine examinations, and to the Public Analyst. A careful perusal of the book has failed to reveal any errors, and, with the exception of a few instances where a difference of opinion may be expected, we find nothing to criticise. The sections on water and parasites may be singled out for especial commendation. The illustrations are invariably accurate, and will allow that sense of safety to the laboratory worker that he is often unable to feel after a scrutiny of the indistinct micro-photographs and diagrams that often have to serve him at the present

THE St. John Ambulance Association has received from Lord Rothschild, Chairman of the British Red Cross Society, two Diplomas of Honour, forwarded by Prince Hilkoff, Secretary of State to his Majesty the Emperor of Russia and President of the Russian Red Cross, awarded to the Association by the Committee of the Empress Marie Féodorovna Funds for the diminution of the sufferings of the sick and wounded in war.

<sup>(</sup>a) "A Manual of Bacteriology, Clinical and Applied." By R. Tanner Hewlett, M.D., F.R.C.P., D.P.H.Lond., Professor of General Pathology and Bacteriology, King's College, London. Third Edition. Pp. 638 + xii, with 24 plates and 72 other illustrations. London: J. and A. Churchill. 1908.

(b) "The Practical Medicine Series." Under the general Editorial charge of Gustavus P. Head, M.D. Vol. VI., General Medicine, 1908, Edited by Frank Billings, M.D., and J. H. Salisbury, M.D. Series 1908. Octavo, pp. 368. Chicago: The Year-Book Publishers.

<sup>(</sup>a) "Dictionary of Medical Treatment for Students and Junior Practitioners." By Arthur Latham, M.D.Oxon., Physician at St. George's Hospital. Octavo, pp. 325. London: J. and A. Churchill. 1908.

<sup>1908.

(</sup>a) "A Compendium of School Microscopy." By E. Godwin Clayton, Fellow and Past Member of the Council of the Institute of Chemistry; sometime Public Analyst for Fulham. Demy 8vo. 1'p. xxxix. and 431, with 282 Illustrations. London: Bailliere, Tindall and Cox. 1909. Price 10s. 6d. net.

# MEDICAL NEWS IN BRIEF.

#### Royal Visit to the London Hospital.

On Monday last, H.M. the Queen and the Empress Marie Feodorovna paid a visit to the London Hospital, Whitechapel. The Royal visitors were received by the Hon. Sydney Holland, chairman of the hospital; Mr. Buxton, vice-president; Miss Lückes, matron; Mr. E. W. Morris, secretary; and representatives of the medical and surgical and nursing staffs.

In the four wards which they visited the Queen and Empress had a kindly word for each of the patients. In the Finsen light department, which owes its origin mainly to her initiative, the Queen remained a considerable time, and talked with several of the patients who are undergoing treatment. From there the Royal wno are undergoing treatment. From there the Royal party proceeded to inspect the new radiant heat baths, installed for the cure of rheumatism, after the style of those in use at Carlsbad. The donor of these baths was Princess Hatzfeldt, whose generosity was directed into this particular channel by a suggestion from King Edward.

In the surgical ward visited were 56 beds, and the visitors did not miss a single patient. They spoke to all in turn, and asked many questions of the matron and sisters in attendance. The Royal party remained at the hospital for an hour and a-half.

#### West London Hospital.

AT the annual meeting of the West London Hospital, Hammersmith, the Duke of Abercorn, President of the hospital, who occupied the chair, appealed for annual subscriptions, and also said there had been a large diminution in legacies and donations. desired to improve the accommodation provided for the nurses. He moved the adoption of the report. The Bishop of London, in seconding, said it was one of the best traditions of our English life that men in positions such as that occupied by their chairman should take a keen and active interest in philanthropic institutions. He himself had earned a certain amount of popularity by sending an injured man in his carriage to that hospital, which was doing an excellent work. It was a kind of lifeboat for that part of London, and he was sorry that it was heavily in debt. The large sum given by the King's Hospital Fund was a distinct vote of confidence, and he hoped the local religious bodies would stand by the hospital.

#### Administration of Anæsthetics.

By the Medical Acts Amendment Bill, which has been drafted by Dr. Cooper, M.P., a medical practitioner applying for registration on or after January 1st, 1911, will be required to submit evidence of having received practical instruction in the administration of anæsthetics, and any person not a registered medical practitioner will be prohibited from administering an anæsthetic, except under certain conditions, to safeguard the rights of all persons registered as dentists before the commencement of the Act. It is also intended to prohibit any certificate of death being given in the case of any person dying under an anæsthetic.

#### Tuberculous Milk.

Out of 456 samples of milk sent to London between January 18th and March 25th last, the examination by the County Council of 299 has been completed, with the result that 37 samples (or 12.4 per cent.) have been proved to be tuberculous. The Council's veterinary inspector visited 125 farms outside the county, and inspected 2,641 cows, of which 92 (or 3.5 per cent.) were found to be suffering from tuberculosis of the udder. In every case in which a tuberculous udder has been diagnosed, the dairy farmer, or his representative, has undertaken to sell no more milk from the affected

#### Seciety for the Study of Inebriety.

THE annual meeting of the Society will be held in the rooms of the Medical Society of London (11 Chandos Street, Cavendish Square), on Tuesday, April

13th, at 4 p.m. (Afternoon meeting). Business:—To appoint Officers and Council for the ensuing Session, and to receive the report of the Council and the financial statement. A short address will be delivered by the President, after which a discussion on "Alcoholism and Eugenics" will be opened by C. W. Saleeby, M.D., F.R.S.E. Each member and associate is at liberty to introduce a visitor. Tea and coffee at 3.45. Council meeting at 3.30.

The minimum annual subscription to the Society being a merely nominal one (5s., including a copy of the British Journal of Inebriety, post free), the Council has resolved that a reserve fund be established to further the work of the Society, and every member and associate, and all interested in the scientific study of alcoholism, are earnestly invited to forward contribu-tions to the Hon. Treasurer, G. Basil Price, M.D., 53. Devonshire Street, Portland Place, W.

Gresham College.

FOUR Lectures will be delivered by Dr. F. M. Sandwith, Gresham Professor, on Tuesday, Wednesday, Thursday, and Friday, April 20th to 23rd, 1909, at six o'clock each evening, the subject being, "Cancer, its History, Geographical Distribution, Theories of Causation, Symptoms and Treatment."

## The Porthcoming Bazaar for Mercer's Hospital and the Orthopædic Hospital, Dublin,

A very influential meeting was held in the Royal College of Surgeons in Dublin on March 30th, under the Presidency of Lady Aberdeen, for the purpose of explaining the results of the work of the promoters of the large bazaar which is to be held at the Royal Dublin Societies premises from May 25th to 29th next, to obtain funds for the hospitals named above. satisfactory reports of the work done were presented to the meeting, and it is evident that the bazaar will be a great success. It is now some time since a bazaar on a large scale has been held in Dublin, and we hope and believe that the promoters' efforts will result in the addition of a large sum to the funds of the

#### Increase of Cancer in Germany.

News reaches us from Germany that Professor Johannes Orth, an authority on cancer, has just published a report on the experiences which he has gathered during a quarter of a century of practical study of this disease. He states that there has been a steady increase of fatal cases of cancer from year to year during the last 30 years, which has advanced beyond the proportionate growth of population from year to year.

Men are, on the whole, he finds, more liable to Certain kinds of cancer are cancer than women. more prevalent among women, but other kinds, such as cancer of the throat, the lip, or tongue, are far more prevalent among men. Cancer of the stomach also appears more prevalent among men. Pro-fessor Orth does not agree with the conclusion arrived at by other eminent physicians that cancer is becoming more prevalent at the earlier ages of patients than was formerly the case.

#### Slavery and Cocoa.

MESSES VAN HOUTEN AND Co., the well-known cocoa manufacturers, ask us to state that in view of the wide publicity which has been given to the fact that certain cocoa manufacturers have at last decided to discontinue the practice of purchasing cocoa beans produced by slave labour in the Portuguese West African territories of St. Thomé and Principe, that during the 80 years they (Messrs. Van Houten) have been producing cocoa, they have never purchased beans grown in slave-affected areas. In selecting the raw material they have always strictly adhered to the policy of purchasing cocoa beans of the highest quality only, produced under the most satisfactory conditions, and they have, therefore, never entertained the idea of procuring beans from West Africa.

#### Unusual Surgical Case.

An inquest was held at Chelsea, on April 3rd, by Mr. C. L. Drew on the body of Alfred James Wilson,

aged 4½ years, the son of a labourer, of Markham Street, Chelsea. The child had been taken to Victoria Hospital to undergo an operation for some brain trouble. During the operation it was found that a small vein had adhered to the scalp and was torn,

causing death.

Dr. Waterhouse said he considered the case unique in British surgery, and it was likely to be of value to

surgeons.

Dr. Spillsbury, pathologist at St. Mary's Hospital, also said that he had never known such a case before. The jury's verdict was "Death by misadventure."

### Reyal College of Surgeons in Ireland,—Prize List, Winter Session, 1908—1909.

Descriptive Anatomy.—Junior.—W. I. Adams, First Prize (£2) and Medal; G. E. Pepper, Second Prize (£1) and Certificate. Senior.—M. J. Hillery, First Prize (£2) and Medal; I. M. Swanepoel, Second Prize (£1) and Certificate.

Practical Anatomy.—First Year.—G. E. Pepper, First Prize (£2) and Medal; H. A. S. Deane, Second Prize (£1) and Certificate. Second Year.—A. G. Mosbery, First Prize (£2), and Medal; I. M. Swanepoel, Second Prize (£1) and Certificate.

Practice of Medicine.—W. V. Johnston, First Prize (£2) and Medal; J. S. Pegum, Second Prize (£1) and

(£2) and Medal; J. S. Pegum, Second Prize (£1) and Certificate.

Surgery.—J. S. Pegum, First Prize (£2) and Medal. Midwifery.—F. W. Warren, First Prize (£2) and Medal; J. S. Pegum, Second Prize (£1) and Certi-

Physiology.—S. Griffin, First Prize (£2) and Medal; M. J. Hillery, Second Prize (£1) and Certificate. Chemistry.—J. C. Sproule, First Prize (£2) and Medal; B. Goldberg, Second Prize (£1) and Certificate.

Pathology.—J. T. Duncan, First Prize (£2) and Medal; T. M. Thomson, Second Prize (£1) and

Physics.—E. Connell, First Prize (£2) and Medal; C. Sproule, Second Prize (£1) and Certificate. The Lectures and Practical Courses of the Summer

Session commenced on Thursday, April 1st.

#### 1 be Measles Epidemic in Birmingham.

THERE are indications of the decline of the epidemic of measles which during the past two months has proved so serious a menace to the children of Birmingham. For several weeks past the death roll has exceeded 40, for the week ended March 22nd it was 46, whereas last week it was only 31, a gratifying decrease of 15 deaths. The improved weather is probably an important factor in the matter, and as the meteorological conditions improve and the temperature advances the number of deaths, it is expected, will continue to diminish.

Last week, too, there was a decrease in the number of deaths attributed to influenza and phthisis. Unfortunately there was an increase in the number of fatal cases of diphtheria and whooping-cough, and therefore, whilst the general death-rate for last week was 21.4 per 1,000 of the population, as compared with 25.1 for the preceding seven days, the zymotic deathrate for the parallel periods was practically the same, being 4.4 per 1,000 for last week, and 4.8 for the previous week.

#### PASS LISTS.

#### **Liniversity of Durham**

First Examination for the Degree of Bachelor of

First Examination for the Degree of Bachelor of Medicine, March, 1909.—The following candidates have satisfied the Examiners:—Elementary Anatomy and Biology, Chemistry and Physics (Honours—Second Class): William S. Murray, Edward Phillips. Elementary Anatomy and Biology.—Robert E. Bell, G. A. Berkeley-Cole, Garfield Carse, Herbert G. Dodd, Cyril Duncan, Idris D. Evans, Reginald A. Hooper, Robert L. Kitching, Nora Murphy, Carinna A. B. O'Neill, Arthur Patterson, Lionel G. Pearson, James M. Phillips-Jones, Evelyn Ritson, Donald C. Scott, Cedric O. Shackleton. Arthur Sutcliffe. Cedric O. Shackleton, Arthur Sutcliffe.

Chemistry and Physics.—Edgar Babst, Philip Gunn, Frederick W. C. Hinings, Sydney E. Murray, Cecil T. G. Pearce, Sidney Scott, Andrew Smith, Herbert J. Shanley.

John S. Arkle passed in Chemistry, Elementary Anatomy and Biology, and Walter A. Elliott in Elementary Anatomy.

Second Examination for the Degree of Bachelor of Medicine (Honours—Second Class).—Sam P. Bedson. B.Sc., passed in Anatomy, Physiology, and Materia Medica.

Pass List.—F. E. Chapman, William L. Clements, Harold Fairclough, Louis E. S. Gellé, James K. J. Haworth, William J. Hickey, Edwin Kidd, William G. Lidderdale, Colin Mearns, Benjamin B. Noble, James A. C. Scott, William A. Slater, Robert W. Smith, Russell V. Steele, Henri R. G. Vander Beken.

Third Examination for the Degree of Bachelor of Medicine.—The following passed in Pathology, Medical Jurisprudence, Public Health, and Elementary Bacteriology.—William G. Bendle (Honours, Second Class), Bloomfield G. H. Connolly, Roger Errington, Francis P. Evers, Eric L. Hancock, Howard T. Hunter, Eva Lumb, Ernest P. Martin, Alfred T. Thompson, Thomas R. West.

#### University of Glasgow.

THE following candidates have passed the Fourth (Final) Professional Examination for the Degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.): -John Allan, James G. Anderson, William (Ch.B.):—John Allan, James G. Anderson, William H. S. Armstrong, Douglas M. Borland, Morris W. Browdy, John A. G. Burton, John Cameron, Matthew I. T. Cassidy, Weir B. Cunningham, James C. Dick, Alexander G. Gilchrist, George S. Gordon, Edward O'D. Graham, James Harper, M.A.; William Howat, M.A.; John P. Kinloch, David N. Knox, Alexander M. Macdonald, Murdo D. Mackenzie, George Macleod, M.A.; Allan M'Pherson, Thomas-Marlin, Henry N. Rankin, Alfred Roemmele, William W. Rorke, William Rutherford, James J. Sinclair, Arthur Turnbull, M.A., B.Sc.; James B. Whitfield, John A. Wilson.

The following passed with distinction in the sub-

The following passed with distinction in the subjects indicated:—In Surgery and Clinical Surgery, Practice of Medicine and Clinical Medicine, Midwifery—George Macleod, M.A. In Surgery and Clinical Surgery, Midwifery—William Howat, M.A.; William Rutherford, Alexander Stewart. In Surgery and Clinical Surgery—Winifred M. Ross, James J. Sinclair, Arthur Turnbull, M.A., B.Sc. In Midwifery—Matthew I. T. Cassidy, John P. Kinloch, Robert C. Robertson, William W. Rorke.

#### Trinity College, Dublin.

THE following candidates passed the Intermediate-THE following candidates passed the Intermediate-Medical Examination at Hilary Term, 1909:—Part II.—Harry L. W. Woodroffe (passed on High Marks), Robert W. Murphy; Arthur F. B. Shaw and H. Jocelyn Smyly (æq.); Francis C. Crossle, James M. Elliott; Hugh M. Fleming, Thomas G. Harpur, Albert E. Malone (q.); Charles O'Brien, Mary G. Caskey, George J. Meldon, Edgar N. Bateman, Gerald P. Beckett, Frank Crosbie, Matthew M'Knight; James Beckett, Ronald G. M'Entire (æq.).

Ernest S. Friel passed the Previous Dental Examination.

MR. JOHN KERSHAW, F.R.C.S., of North Drive, St. Annes-on-the-Sea, Lancs., who died on February 14th, left estate of the gross value of £79,195 3s. 7d., of which the net personalty has been sworn at £67,129 9s. 1d. The testator bequeathed £10,000 to be distributed by the executors in accordance with memoranda left by him; and to the Victoria University of Manchester his Egyptian Canopus (Cynoce-The residue of his property he left upon phalus). trust for the founding, establishment, maintenance, or endowment of a general hospital and infirmary in the township of Royton, Lancashire.

#### **NOTICES TO** CORRESPONDENTS. &c.

Conrespondence requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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SUBSCRIPTIONS.

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KATHERINE X.—You will want a microscope on your expedition. It should, however, be capable of standing hard wear, and at the same time be strong and portable. If you care to write us more fully, we will make inquiries in the proper quarter. Horfield (Bristol).—Those who talk so earnestly about the necessity of reducing the infantile mortality would do well to try and lessen the evil by checking the sale of patent medicines, which are, beyond a doubt, responsible for many deaths of infants and young children.

ARMI SURGEON.—We are well aware of the elaborate methods of gastrio investigation which you describe. In the opinion of many leading physicians they should be relegated to the laboratory, as they do not, as a rule, advance either diagnosis or help treatment.

MISTURA FERRI GALLICI.

To the Editor of TRE Medical Press and Orrecular.

SIR.—Your comments in last issue on above subject are amusing, and, I presume. ""concal." The idea of feeding hens on rust derived from nalls, scraps of iron, etc., emanates, of course, from a "lay" journal, a "foul" suggestion at best. In course of time, by evolution, the bens might be induced to layer priately stored in the hatchway of warships, and when supply became short the ship might be obliged to "lay to" anyway!

I am, Sir, yours truly,

A. D.

A. D.

London, W.

SURGEON-GENERAL O'D.—It is a fact that Poor-law children cannot be sent by Guardians to the training-ship Exmouth, except with consent of the parents. No doubt that difficulty accounts for the small use that is made of that most excellent organisation by local authorities. A service would be done to the ratepayer, as well as to the naval authorities, were the many advantages offered by the training-ship Exmouth to be widely impressed upon the public.

T. A. CROTHERS.—Although the spread of measles has never been actually traced to the agency of flies, it would be unsafe to exclude that possibility from any detailed scheme of prevention.

EUTHANASIA

to exclude that possibility from any detailed scheme of prevention.

EUTHANASIA.

EUTHANASIA is a word of various meanings. The sense in which you use it, namely, that of putting to death human heings who are hopelessly sick, or otherwise useless to society, is no new idea in the speculations of moral philosophy. Some persons hold that it would be better to begin at the other end of the stick, and prevent the marriage of the unfit, and at the same time destroy defective infants. It will probably take a good many centuries for mankind to arrive at a satisfactory solution of the problem. Pessibly eugenics may out the Gordian knot by evolving a perfect race.

Labrador.—The fruit of the pincapple, it is stated, contains a digestive principle closely resembling pepsin in its action. On the casein of milk pincapple juice acts as a digestive in almost the same degree as rennet. Hence the juice is indicated in some forms of dyspepsia.

Dr. W. H. B.—Statistics have recently shown that the birthrate is falling in the United States, and not increasing, as our correspondent suggests. In a lecture delivered at the Cornell tuiversity on Births and Birth-rate, towards the end of last year, the statement was made that from 1860-1900 the proportion to each 1,000 women of child-bearing age in the United States has decreased by 152, or an average of about 30 in each decade. This means that the continuance of this decrease, if unchecked, would, in a century-and-a-half, eliminate the birth-rate entirely.

## Meetings of the Societies, Tectures, &c.

WEDNESDAY, APRIL 77H.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tettenham, N.).—Clinics: 2.30 p.m: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

THURSDAY, APRIL 87H.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.50 p.m.: Gynrocological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X.Rays. 5 p.m.: Medical In-patient (Dr. G. P. Chappel). Demonstration: Dr. F. Thomson: Infectious Fevers (at the North-Eastern Fever Hospital, St Ann's Road, N.

FRIDAY, APRIL 97H.

NORTH-EAST LONDON POST GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.50 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

MANSON, J. S., M.B., Ch.B.Edin., Honorary Assistant Surgeon to the Warrington Infirmary.

MILINE, LINDSAY S., M.B., Ch.B.Edin., First Assistant in the Russell Sage Institute for Pathology, New York, U.S.A.

MORDE, EDWARD, L.R.C.P. and S.Edin., Medical Officer of Health of Torrington (Devon, M.B., C.P.Lond., M.R.C.S., Medical Superintendent of Wonford House, Exeter.

ROSE, WILLIAM, M.B., B.S.Lond., F.R.C.S.Eng., Consulting Surgeon to the British Hospital for Mental Disorders and Brain Diseases, Camden Road, N.W.

SIMPSON, HAROLD C., L.M.S.S.A.Lond., Medical Officer of Health for the Skirlaugh Rural District Council, Hull.

WHITE, CLIFFORD, M.D., B.S.Lond., M.R.C.P.Lond., Pathologist and Registrar to Queen Charlotte's Lying-in Hospital.

#### Vacancies.

Birkenhead Union.—Resident Assistant Medical Officer. Salary. £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poor-Law Offices, Conway Street, Birkenhead.

Metropolitan Borough of St. Marylebone.—Medical Officer of Health. Salary, £500 per annum. Applications to James Wilson, Town Clerk, Town Hall, St. Marylebone, W. County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer. Salary, £150 per annum, together with furnished apartments, hoard, attendance, and washing. Applications to the Medical Superintendent.

Township of Manchester.—Assistant Medical Officer. Salary, £130 a year, with furnished apartments, fire, light, washing, and attendance. Applications to James Macdonald, Clerk to the Guardians, Poor-Law Offices, New Bridge Street, Manchester. Urban District Council of Barking Town.—Medical Officer of Health. Salary, £350 per annum. Applications to H. Hargraeves, Clerk, Public Offices, Barking, Essex.

Staffordshire County Asylum, Cheddleton, Leek.—Temporary Assistant Medical Officer. Salary £150 per annum, with apartments, board and washing. Applications to the Medical Superintendent.

The Hospital for Sick Children, Great Ormond Street, London. W.C.—House Surgeon Salary £30 for six months, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary. (See advt.)

The Hospital for Sick Children, Great Ormond Street, London. W.C.—Assistant Casualty Medical Officer. Salary £30 for six months, washing allowance £2 10s., and board and residence in the Hospital. Applications to the Secretary. (See advt.)

#### Births.

ARMSTRONG.—On March 30th, at Jaffna, London Road, Reading, the wife of Dr. E. Frankland Armstrong, of a son.

SCOTT.—On March 31st, at 46, Queen Anne Street, Cavendish Square, London, the wife of Sydney R. Scott, M.S.Lond., F.R.C.S.Eng., of a son.

SMITH.—On March 30th, at Digby House, Melton Mowbray, the wife of James A. Smyth, M.B., of a son.

#### Marriages.

DICKEY—CARTER.—On March 27th, at Christ Church, Turnham Green, William Crautuird McNaghten Dickey, M.R.C.S.Eng., L.R.C.P.Lond, only son of W. Crautuird Dickey, dental surgeon, of Chiswick, to Rosamond Alice, only daughter of Mr. and Mrs. Charles Carter, of Brighton.

#### Beaths.

GEOGHEGAN. - On April 2nd, after a long illness, Alfred Osmond Geoghegan, M.D., Lieut. - Colonel R.A.M.C. (Retired), in his 53rd

Geoghegan, M.D., Llett., Colonier R.A.M.C., (Newfield), in his con-year.

GRAY.—On April 2nd, at The Grange, Westbourne Road, Birkdale,
Alice Penrose Gray, aged 43, widow of the late Andrew Gray,
M.D., 8t. Helens, and daughter of E. P. Twyford, M.D., late of
St. Helens.

Ramsbortham.—On March 30th, at Fairstead, Harrogate, Samuel
Henry Ramsbotham, M.D.Edim., M.R.C.S.Eng., late of Leeds,
oldest son of the late John Hodgson Ramsbotham, M.D.,
F.R.C.S., aged 70 years.

Wilson.—On March 31st, at the London Hospital, of blood poisoning, after a short illness, Angus Bewley Wilson, M.B.Cantab.
house physician, second son of A. Christy Wilson, M.D., Hall
trate, Doncaster, aged 32 years.

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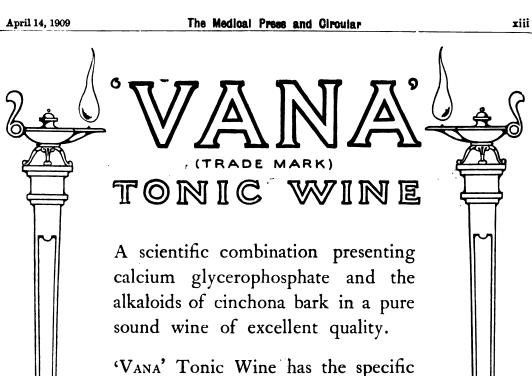
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N.B.—It has been found necessary to substitute the term "Rideal-Walker Co-efficient" for that originally introduced by the authors, viz.. "Carbolic Acid Co-efficient," owing to the abuse of the latter on the part of unscrupulous manufacturers and vendors.—Vide British Medical Journal, April 6, 1907.

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, APRIL 14, 1909.

No. 15.

### Notes and Comments.

Appendicitis. and Corsets THE ætiology of disease is one of the most difficult parts of medicine, and the exact causation of many maladies is a subject of great doubt to medical men. To the gentlemen

who write for newspapers, both in the editorial and advertisement columns, there are no such hindrances to knowledge, and the cause of disease may be either evolved out of the writer's inner consciousness on the spur of the moment, or a theory may be obtained at equally short notice from the proverbial well-known Harley Street specialist. After having invented a cause, the next process is to continue to harp on it till the public are convinced of its truth, and when this desirable end is accomplished comes the final stage, in which the journalist triumphantly upsets the theory, and shows how wrong the public have been all the time. An instance of this entertaining game has been going on of late. Some quill-driving pathologist discovered that the wearing of corsets was the cause of appendicitis, and good ink and paper were wasted in the crusade of impressing the world with the momentous fact. Finally came the débacle in the shape of quotation by a weekly paper of some remarks made by Dr. John B. Murphy, of Chicago, who pointed out the fact that as appendicitis is four times as common in men as in women, corsets could not be an ætiological factor. We can only trust that this will lay that ghost for the time being.

THE British Dental Association are "Hygienic fortunate in being armed with a Institute" in better instrument for offensive purposes than the Medical Act, and they are showing creditable activity in availing themselves of its provisions for the suppression of unregistered dental practitioners. amusing and interesting prosecution took place at their instance at Bishop Aukland on the first of this month, when the local manager of a business calling itself the "Hygienic Institute" was summoned for unlawfully representing himself to be a duly qualified and registered dentist, contrary to the Dentists Act, 1878. For the purposes of obtaining evidence, two policemen, disguised as working men, had gone to the Institute, and one of them asked for the dentist. The manager came forward, and when asked, "Are you the dentist?" replied, "I am." The constable then consulted him about a tooth, which Smith, the manager, advised him to have pulled out at the cost of a shilling. In an adjoining room into which he was shown was an operator who injected something into the gum, and pulled out the tooth while Smith held the patient's head. There is something

irresistibly comic in the idea of a policeman going to collect evidence against an unregistered dental practitioner, and in his devotion to duty going so far as even to allow one of his teeth to be extracted. Or did he, we wonder, take this as a favourable opportunity of getting a troublesome tooth pulled out at the expense of the county funds?

As, however, the tooth came out in due course, and the constable de-Fines, Damages, and clined to have a second one extracted, Appeals. it may be that it was really professional zeal that prompted the heroic act. The manager being called to give evidence on his own behalf, admitted that he had only been in the business about a year, but, with some reluc-tance, admitted that prior to this he had been a traveller for a firm of wholesale fruit merchants! The Bench found him guilty of a breach of the Act, and fined him £5 and £3 13s. costs, declining to allow an appeal on the question of fact, but agreeing to state a case on the point of law. Even more unfortunate was the Institute at Cardiff, for there a civil action was brought against them for £100 damages for the alleged ignorance and unskilfulness of the persons in their employ, with the result that the jury awarded the plaintiff £60, though here, again, an appeal was granted. It is an interesting fact that though the public are so ready to prosecute medical men whom they suspect of having injured them by lack of care or skill, yet they seldom seek redress from unregistered or irregular practitioner for the same offence. It would seem to follow as the night the day that an unregistered dentist has, legally, not sufficient skill to practice dentistry, and that, therefore, any person who consults him, provided there was no false representation, has only himself to blame.

Poor-law but almost necessary type, in which Regulations and Emergency. patient without his fee being guaranteed, has occurred at West Hartlepool. It seems that an unknown man was taken ill in the street, and, after being carried into a neighbouring house, the police were informed by

a neighbouring house, the police were informed by a bystander. The superintendent of the police then telephoned to the Poor-law medical officer, requesting him to attend, and the doctor asked if the police would be responsible for his fee. Being told "No," apparently he said he would not attend without an order, but almost immediately afterwards a message arrived that the man had died. An inquest was held in due course, and these facts were stated in evidence, and the jury, after finding that death was due to apoplexy, added that they desired to express

their disapproval of the conduct of the parish doctor in refusing to attend without his fee being guaranteed. It is most unfair that in cases such as this private practitioners should be made the scapegoats of a thoroughly bad system. As parish medical officer, the doctor can only attend on an order, and consequently any service rendered has to be given in his private capacity. The police refused to be responsible for his fee and did not send their own surgeon, who, presumably, could have charged a fee. It is invidious in the extreme that medical men should be placed in such situations and made to bear the brunt of the meanness and short-sightedness of local authorities.

South-West London Inquests. MR. TROUTBECK seems to carry on the process of conducting inquests on patients who die after operations, though, considering the number of large hospitals and infirmaries in his

districts, it is difficult to know on what principle he appears to select deaths at the Bolingbroke Hospital for his special attention. Also, it would also be interesting to learn at what period after an operation a patient may die without his relatives incurring the unnecessary pain and distress of an inquest, If, as Mr. Troutbeck maintains, an operation is an "accident," presumably the law as to length of time pertaining to deaths after accidents applies to deaths after operations, in which case the time of his courts would be pretty well filled up in inquiring into all such cases. Indeed, if Mr. Troutbeck is sincere in his view and abides by his own interpretation of the Coroners' Act, he should at least be consistent. We have no definite information as to how many of these deaths are really made the subject of inquests, but from the number reported we judge them to be few and spasmodic. If we are correct in this conjecture, it is neither creditable to Mr. Troutbeck's sources of information nor to his determination. It seems to us that there is a hiatus, a gross hiatus, and that it should be bridged over.

Evidence Thereat. We note also that the person selected to perform the post-mortem is still Dr. Freyberger, and that he is called upon to tell the jury the cause of death. Now, although the surgeon

death. Now, although the surgeon be also called, it is plain that Dr. Freyberger's knowledge of what took place at the operation is simply hearsay, and although the coroner's court is a law unto itself, it is pertinent to point out that such evidence is rightly regarded as worthless in every English court of law. If Mr. Troutbeck insists on having a "special pathologist," it would be as well to confine his evidence to facts actually noted by himself and to deductions drawn from those facts, uninfluenced by what may be told him by others. In the report of a case before us, in which a patient had died after an operation for cancer of the bladder, Dr. Freyberger is reported to have said: "Death was caused by sudden failure of the heart in consequence of the shock of a prolonged operation, while the deceased was suffering from the effects of cancer." And, again, in another case he is reported as having said: "Death was due to heart failure in consequence of collapse caused by the gangrenous state of the bowel. He could not entirely dissociate from the death the shock caused by the anæsthetic."

Legal Purism. WE have never maintained that the advice of a recognised pathologist might not be usefully sought in a certain class of cases of pathological difficulty. Such difficulty, of course,

did not exist in these instances, and there was no

need for a pathologist. In both cases the operating surgeon was called, and his evidence as tothe cause of death and the necessity of the operation would far outweigh in value that of a pathologist. In fact, Dr. Freyberger's evidence was totally unnecessary, and if he had confined himself to facts observed would merely have been unnecessary. When, however, he says that an operation is a "prolonged" one, it is obvious that he is speaking of facts outside his own knowledge, and when he says that gangrenous bowel has been a cause of death, when the gangrenous bowel had been removed at the operation, it would seem that he is doing so again. Mr. Troutbeck holds himself out as a lawyer and glories in his interpretation of the law, though most other people, including the late Lord Chancellor, think he is mistaken. But obviously if there is any value in a special pathologist's evidence, it is confined to a strict adherence to facts within his observation, and if the reports before us are at all correct, even this elementary legal maxim is disregarded in this court of law.

#### LEADING ARTICLES.

THE QUACK MEDICINE PERIL.

For years past the question of infantile mortality has been pressed upon the public attention. In season and out of season the matter has been discussed from every possible standpoint, and the community have been very properly educated upon the preventability of much of the yearly "massacre of the infants," as it is termed by a certain class of journalists. Nor can it be doubted that much good has arisen from the agitation. Such topics as the proper eeding of infants, the special dangers of infantile maladies, the need of isolation in infectious disorders, and the bearing of tuberculous milk upon tuberculosis in children have all been brought home to parents by a thousand agencies, voluntary and official, in all parts of the kingdom. One most important addition to our comprehension of the whole subject has been the demonstration by Alderman Broadbent in Huddersfield, and by practical philanthropists elsewhere, that given an additional incentive in the shape of a premium, the infantile mortality of a given district could be materially reduced. It would be difficult to devise any more absolute logical test of the preventability of a large percentage of the infantile death-rate in a modern town population. Curiously, the share taken by quack medicines in the needless destruction of child life has not taken the prominent place in the public attention to which, in our opinion, it is justly entitled. It seems more than likely that the facts of the case can only be brought out with anything like sufficient fulness by the agency of a Royal Commission. The unchecked existence of so grievous a drain upon the life of the country presents an extraordinary contrast to the zealous. care with which life is protected by the State in other directions. If it be desirable to protect the health of the community and to reduce mortality to its lowest possible ratio, then it

becomes at once imperative to control so injurious and destructive an agency of mischief as that inflicted by the sale of secret remedies. State, however, which tacitly permits the sale of nostrums for children by anyone who pays the stamp duty, exercises no greater care over adult citizens. The terrible injury wrought by patent medicines was fully revealed in the recently issued report by the Australian Government Inquiry. The facts demonstrated therein apply with equal force on our own side of the globe, for the operations of the advertising nostrum vendor are world-wide as his capital is unbounded and his cynical disregard of all interests but his own is unparalleled. Sooner or later the legislature will have to be compelled to turn their attention to the matter, and we have consistently maintained in the columns of THE MEDICAL PRESS AND CIRCULAR that the best way of going to work would be by way of Royal Commission. The suggestion deserves the close attention of members of the medical profession, who are daily brought face to face with the evils arising out of the traffic in patent medicines, and who are capable of exerting in the aggregate a potent influence upon the mind of the nation. Were all medical practitioners, for instance, to advocate strenuously that in future every patent medicine should bear on its label a statement of its ingredients, a flood of light would be thrown upon the nature of a trade that can thrive only in secrecy. Were such a condition enforced by the legislature, this nefarious trade would receive a deadly blow which would infallibly deprive it of a vast deal of its powers for mischief. The practical Germans, with their inherent love for hard-headed social legislation, have long ago adopted this simple plan. In Germany the purchaser of a patent medicine knows the exact composition of the stuff he is buying. What a contrast from the state of affairs in the United Kingdom, where poisons and injurious drugs are sold wholesale for the "cure" of a thousand different complaints under the ægis of a government stamp! Short of legislation we have long claimed that the police have ample existing powers to check the sellers of nostrums professing to cure hopeless maladies as locomotor ataxy, cancer, and so on, or to "cure" fifty complaints with one remedy, and that often of a worthless nature. The short and simple plan of prosecuting such gentry for obtaining money under false pretences would possibly obviate the need of special legislation. We commend this view of the matter to Mr. Herbert Gladstone, in the hope that he may find time to enforce some such policy in the important Government department over which he presides with dignity and distinction. No statesman could find a more solid and permanent claim to the gratitude of the nation than that which will be due to the Hercules who sweeps clean this Augean stable of quackery.

THE STATE AND THE MOTHER.

THERE are few subjects of more general interest or of keener controversy than the falling birth-rate. Of the fact that families are becoming more limited in numbers there is, of course, no doubt. Not only does this obtain in Great Britain, but in all civilised countries where proper statistics are kept, the same phenomenon is shown. We omit from the term "civilised countries" dominions such as Russia, where a condition resembling mediæval barbarism reigns wholly or partially. The fashion is to deplore this fall and to prognosticate all sorts of woes, degeneration, decline, and national extinction for the populations so affected. The other side of the question is that, generally speaking, where the birth-rate is high the infant mortality is large, and where the birth-rate is low the infant mortality is low. Without arguing about the causes of these phenomena, the desirability of one state of things, or the undesirability of the other, it is pertinent to observe that since the British birth-rate shows a tendency to fall, the duty of preserving infant life is correspondingly important, even if no question of morality or duty comes in. It will hardly be a matter for dispute that the path to prevention of infantile deaths lies through the mother, and whether by education, legislation, subsidy, or what not, so long as the value of home life and home influence continue to be regarded with the just veneration which they command at the present day, the State mother solution will be put aside in favour of the fostering of the natural or home mother. State care of the pauper, as represented by the guardians, has not been so brilliant a success as to invite one to attempt to construct the municipal crêche, with the municipal wet-nurse to take the place of the domestic hearth and the "own" mother. Difficulties in the way there are in battalions. The mother may be educated to the duties of motherhood; she may be lectured to, demonstrated to, and rounded up by health visitors, who, being estimable ladies with no children of their own, are reckoned to be better able to instruct working-class mothers than women who have had the nurture of a numerous progeny. Without decrying these efforts, indeed, while according all praise to the good they contain, we naturally ask if, supposing education of the mother be raised to university pitch, the question of infantile neglect and mortality would be solved? To that question there can be but one answer. Where maternal ignorance kills its hundreds, maternal inability to carry out the counsels of perfection in which she is instructed slays its thousands. It is easy enough to tell a mother to feed her infant every two or three hours, to give him as much sleep as possible, to train him into habits of regularity, to keep him constantly warm, and so on; but when a month after her confinement a mother has to go out to work for ten or twelve hours a day, advice of this kind is like sounding brass and tinkling cymbals. The real fact is that the mother should never go out to work, and that she should not be made to do more than is consistent with whole-hearted devotion to her baby. Theoretically, a working-man in full employment, even with a fair-sized family, should earn enough to keep things going, but practically the necessity of mothers going to work is

frequently very great. When the husband is ill and when he is unemployed, the wife has to go out if the mouths are to be filled without recourse to the Poor-law; widows with young children have to support their families by labour; and in some households the expenses are so large that the man's earnings have to be supplemented by the woman's. In poor neighbourhoods these circumstances are the commonplaces of life, and while such occupations as office-cleaning, charing, and many kinds of the less-well-paid forms of labour are considered to be "women's work," the man has often to rely on his wife for help in times of poverty and stress. We believe this matter of the employment of mothers to be one of the most urgent and complicated problems of the day, and we certainly see no royal road to its solution. Mr. Robert Harcourt, M.P., has just introduced into the House of Commons a Bill entitled the Local Authorities (Necessitous Mothers) Bill, which seeks to raise the standard of motherhood, and to secure supervision lest the responsibilities of maternity be neglected. Mr. Harcourt endeavours to make pregnant and nursing mothers remain at home and abstain from heavy physical labour, and to enforce on them the advantages of suckling their infants. He seeks to co-ordinate the Public Health authority with the Poor-law authority in securing supervision of the mother combined with monetary relief, and to provide the necessaries of life to the mother during the time she is nursing. Wholly praiseworthy as is the Bill in intention, we do not believe that inspection of this type is good for good mothers, and we are sure that habitual recourse to the Poor-law authorities cannot, in the long run, be beneficial to the sense of respectability and self-respect. Yet the problem remains, and we should be infinitely glad if some Napoleonic brain would indicate a simple and practical method of dealing with it.

#### CURRENT TOPICS.

#### The Territorial Medical Service.

SIR ALFRED KEOGH, Director-General of the Army Medical Service, may be congratulated on the encouraging success that has so far been obtained in the attempt to place the Territorial Medical Service on a sound footing. The wave of enthusiasm which has created a great citizen army within a brief space of time has happily ncluded that most important branch of organisation which deals with the care of the sick and wounded in war. So far as the Metropolis is concerned a most satisfactory state of affairs is reported. The 3rd London Field Ambulance Corps, for instance, has reached its full establishment of 230, and last year's camp was attended by 159 members of the 185 then on the roll. The two general hospitals in connection with the London force are also complete. Good work of a similar kind has been done all over the country by the consolidated corps which the Medical Service now represents. In future warfare the efficiency of the medical arm will probably rank as one of the most essential features of a first-rate military organisation.

# Poor-Law Infirmaries and Medical Teaching.

THE bettering of the conditions of Poor-law infirmaries has been one of the not least remarkable features of modern social progress. However cold and repellant the workhouse and outdoor poor relief may be to inmates and recipients, a very different atmosphere pervades a modern up-to-date Poor-law infirmary. Everything is bright, cheerful and well appointed, good wards, good nursing, highly skilled medical attentionin a word, both equipment and maintenance are up to the level of a first-rate voluntary hospital. In this way a vast amount and variety of disease is dealt with under the best modern scientific conditions, and an unrivalled field is furnished for the purpose of clinical medical and surgical teaching. The ratepayers who furnish the lowest expenditure necessary to Poor-law infirmaries might with reason ask that medical education might be advanced thereby. In the long run it. is clearly in the interests of the public that every possible facility should be afforded to the medical schools in their efforts to turn out well-educated medical practitioners. The waste of clinical material under the present system is obvious, and has long since attained the dignity of an accepted truism. For all that, its virtues appear to be strongly overlooked in the many schemes for Poor-law reform that are from time to timelaid before the public. Possibly the Asylums may one day be induced to lead the way in organising a scheme for co-ordinating their vast hospital organisation with the teaching forces of the medical schools.

#### Death Under Chloroform and the Compensation Act. The question of the administration of anæsthetics

has cropped up under various guises in legal actions arising out of the Workmen's Compensation Act. One of the most recent decisions upholds a claimant who refuses to undergo a remedial operation, provided he can obtain the support of a single medical man in his objection to surgical intervention. Last week another decision of farreaching importance was delivered by the Master of the Rolls in the Appeal Court. Some time agoa Stalybridge man in the employ of the Calico Printers' Association, Ltd., met with an accident in the course of his employment. At a subsequent date he, while undergoing an operation, unfortunately died whilst under the influence of the chloroform. The County Court Judge before whom the claim for compensation was brought disallowed the application. On appeal, however, the Master of the Rolls said the County Court Judge had misdirected himself, for the step taken by the workman was not only courageous, but was, moreover, in the interests of his employers. The case was accordingly remitted to the County Court, not for the purpose of re-hearing, but to assess the amount of the compensation.

#### Proposed Legislation against Research.

The opponents of research by experiments on animals are making themselves active in the present

session of Parliament, no fewer than four Bills dealing with the subject having been introduced. Two of these have been brought forward by such "whole-hoggers" as Sir George Kekewich and Mr. Hodge, and aim at the entire suppression of experiments on living animals. Another, for which Mr. George Greenwood is chief sponsor, is much less far-reaching in its aims, and is directed toward imposing further restrictions as regards the granting of licences for research, and toward increasing the powers of inspection. This Bill, by a stroke of luck, came up in the early morning of the all-night sitting on the Annual Army Bill, and was advanced a stage. The fourth measure before the House is the Dogs Protection Bill of Sir F. Banbury, which prohibits under severe penalties all experiments on dogs. None of the Bills are likely to go far, and it was only by unusual luck that the Cruelty to Animals Bill came up last week.

# Administrative Measures against Tuberculosis.

DR. NEWSHOLME, the Medical Officer of the Local Government Board, has issued a valuable memorandum on administrative measures against tuberculosis. Its object is to supplement, from a medical standpoint, the information contained in the circular letter issued recently to all sanitary authorities by the Local Government Board. Dr. Newsholme wishes to direct activity in particular towards two ends-early recognition of the disease and the prevention of infection. As an aid to early diagnosis, it is important that practitioners should have vailable a free bacteriological examination of the sputum. Moreover, it is hoped, and with reason, that the medical inspection of school children will lead to an earlier recognition of many cases. For the prevention of infection various administrative measures are required. Of these the chief is the general education of the public and of school children in matters of hygiene, and more particularly instruction of those specially liable to infection by tuberculosis. To this class would belong not only those in close contact with the infected, but others like barmen, potters, cutters, hairdressers, who are most exposed to infection by reason of their occupation.

#### Unreadable Prescriptions.

THE illegibility of the prescriptions of medical men has become proverbial. So fixed is the characteristic that it must be accepted as significant of some determining condition of professional life. It may to some extent be due to long use of surgery pens of varying degrees of badness, and partly to the little care bestowed upon the mere mechanical act of writing by energies that have but recently emerged from the strain of determining diagnosis and treatment. But whatever the real origin, the outstanding fact remains that the handwriting of the average medical man is unutterably bad. Happily from long practice in its interpretation, the chemists can as a rule read what are hopeless hieroglyphics to the man in the street. The remedy is not easy to find. Possibly the General Medical Council might attach extra marks to caligraphy in the scheme of preliminary medical education, or insist upon production of evidence of capability to write legibly before qualification. In any case, it is clear that some extra precaution should be taken when a bad writer is ordering poisonous or otherwise dangerous drugs.

#### PERSONAL.

PRINCESS CHRISTIAN visited Purley on March 31st in order to open a Cottage Hospital built by subscriptions raised in the district. The High Sheriff of Surrey, Sir Frederick T. Edridge, welcomed her Royal Highness on behalf of the committee.

THE John Tomes Dentil Prize for 1906-1908 was awarded to Mr. Arthur Swayne Underwood, M.R.C.S., L.D.S.Eng.

SIR RICHARD DOUGLAS POWELL, M.D., was reelected President of the Royal College of Physicians of London by a practically unanimous vote, recorded on the 5th inst., at a Comitia of the College.

INSPECTOR-GENERAL JAMES PORTER, C.B., M.D., Director-General of the Medical Department of the Navy, has been appointed Honorary Physician to the King, in the place of Inspector-General Sir John Watt Reid, K.C.B., deceased.

AFTER two years spent in Central Africa investigating, on behalf of the Liverpool School of Tropical Medicine, means of checking the spread of sleeping sickness, Dr. Kinghorn and Mr. Montgomery have returned to England.

THE DUKE OF DEVONSHIPE has been unanimously elected President of the West End Hospital for Nervous Diseases, in succession to the late Lord Egerton of Tatton, and Mr. H. C. Willock-Pollen has been elected Vice-Chairman in the place of the late Mr. A. W. Elam.

THE Jacksonian Prize was awarded to Mr. J. P. Lockhart Mummery, F.R.C.S., for his essay on "The Pathology and Treatment of those Conditions and Diseases of the Colon which are Relievable by Operative Measures."

At the annual Graduation Ceremonial at the Unversity of St. Andrews, which took place on March 31st, the honorary degree of LL.D. was conferred upon Dr. James Wallace, D.Sc., M.D., F.R.S., Professor of Chemistry in the University of Edin burgh.

THE Radcliffe Prize for 1909 in the University of Oxford has been awarded by the Master and Fellows of University College, upon the report of the examiners, to Dr. Arthur Frederick Hertz, formerly Demy of Magdalen College. The subject of Dr. Hertz's dissertation was "The Physiology and Pathology of the Movement of the Intestines."

THE Lady Mayoress presided on the afternoon of March 31st at a drawing-room meeting at the Mansion House in connection with the Royal Institute of Public Health, for the purpose of calling attention to the need of hygiene in the home. Her Majesty the Queen and Her Royal Highness the Princess of Wales have consented to become patroness and vice-patroness respectively of the Ladies' Committee in course of formation.

At the last quarterly meeting of the Council of the Royal College of Surgeons of England on April 1st, Sir Shirley Murphy, Medical Officer of Health to the County of London, and Mr. G. Dancer Thane, Professor of Anatomy at University College, London, were elected Fellows of the College under the clause of the Charter relating to the election of members of twenty years' standing.

## A CLINICAL LECTURE

ON

# DUODENAL ULCER: ITS DIAGNOSIS AND SURGICAL TREATMENT. (a)

By JAMES SHERREN, F.R.C.S.,

Assistant Surgeon to the London Hospital, Surgeon to the Poplar Hospital for Accidents.

Part II.—(Concluded from page 348.)

Prognosis after Perforation.—Without operation, perforation of a duodenal ulcer is fatal in almost every case. With operation, the death-rate is much greater than in perforation of gastric ulcers. For example, in the past six years I have operated upon eleven cases of perforated duodenal ulcers, of whom eight died, and upon fifteen cases of perforated gastric ulcer, of whom seven died. The mortality figures for these two conditions at the London Hospital for the last ten years, which have been taken out by Mr. Milne, Surgical Registrar to the Hospital, show the same difference. Thirty-two cases of perforated gastric ulcer have been operated upon, with a death-rate of 67.4 per cent.: 42 cases of duodenal ulcer, with a death-rate of 80.9 per cent. A similar difference is shown in the figures given by Crisp English for St. George's Hospital for the years 1892-1903—42 gastric ulcers, with a death-rate of 42 per cent.; 8 duodenal, with a death-rate of 75 per cent. The high death-rate at the London Hospital is due to the late period at which many of these cases are admitted. In the district drained by the Hospital, medical advice and operation are put off as long as the patient thinks is possible. Mayo Robson collected 155 cases of perforated duodenal ulcers, with a death-rate of 66 per cent., but of these 61 were operated upon within the first 24 hours, whereas in the London Hospital cases 6 would be the outside number of early

To what can the difference in the mortality in gastric and duodenal ulcers be attributed. Considering that many of the cases of perforating ulcers of the duodenum are just at the pylorus, and produce a sudden onset of symptoms, I think it must be due to the relatively less severe symptoms in some cases, which render an early diagnosis less likely, particularly in ulcers situated in the second part or the junction of the first and second portions. The death-rate of the first group into which I divided the symptoms of perforating duodenal ulcer is the same as that of perforative gastric ulcers operated upon at the same time after perforation.

It is in the second group of cases in which the symptoms arise more insiduously, that diagnostic difficulties and consequent delays in resorting to operative measures arise. As the knowledge increases that all cases of sudden abdominal pain must be considered surgical, so the death-rate will diminish. As individual experience increases and attention is drawn to the difficulties, there is no doubt that even in hospital practice the death-rate will diminish markedly in the next few years. But the ideal state is to diagnose and operate upon these cases before perforation.

Turning now to the cases of chronic duodenal ulcer before perforation has taken place. What are the symptoms which are met with in these cases? Is it a condition easy of diagnosis? A vivid description of the symptoms in a typical case has been given by Moynihan, and I cannot do better than quote this. "The symptoms of duodenal ulcer are, in the great majority of cases, sufficient to enable a diagnosis to be made without any physical examination of the patient. The anamnesis is to this effect. After food is taken, the patient is free from pain, the period of an hour or two which follows a meal, is the best time of the day. At a time varying from 1½ to 4 hours after the meal, a sense of uneasiness is noticed in the upper part of the abdomen. A burning gnaw-

(a) Delivered at the Medical Graduates' College and Polyclinic.

ing sensation develops, and there is a bitter taste in the mouth, with it may be eructation of food or gas, bitter and acid in taste. The pain, which gradually increases, may be relieved, often considerably, by belching or by pressure. As it increases in severity it strikes through to the back, to the right of the middle line, and it may radiate round the right side of the chest. As all patients discover for themselves, the taking of food relieves the pain. . . The more substantial the food the greater the interval of relief. If meat is taken in good quantity there will be a long period of ease; if only fluid foods are taken, the relief is short or not experienced at all."

If these symptoms are present I am in agreement

If these symptoms are present I am in agreement that the case is one of ulcer of the duodenum, but, unfortunately, such a typical history is by no means

always to be obtained.

It must, however, be pointed out that the mere fact that pain is present after food, relieved by a warm drink or by sodii bicarb. is not sufficient to enable us to diagnose duodenal ulcer. These symptoms must persist in spite of medical treatment, or recur after treatment. It must also come on at least an hour and a-half after food, for in some cases the pain in chronic gastric ulcer is also relieved by taking food or sodii bicarb.

All observers are agreed that pain is the most important symptom, pain coming on at a considerable interval after food, often waking the patient at night, and relieved by food. In many of the cases seen at the present time, when the ulcer has been in existence for years, vomiting is present, due to dilatation of the stomach, and in these late cases melana is often noticed, the patient giving a history of attacks of faintness, followed by the passage of blood. In only one of my cases was melæna the most prominent symptom.

To review now the 13 cases of chronic duodenal ulcer upon which I have operated before perforation occurred. Twelve were males, and of these nine were correctly diagnosed before operation, and fell into group two. These were all males, and although in no case was the history so typical as that I have quoted yet, it was sufficiently so to make the diagnosis evident. In all, pain coming on an hour and a-half to two hours after food and waking the patient at night was a prominent feature. Vomiting was not often met with unless dilatation of the stomach had supervened, and if met with did not often relieve the pain, although one patient induced vomiting in order to do so.

I have been struck in looking through my notes by the long period during which the patients had had symptoms, and in many cases had been treated

medically.

Out of the 13 cases, the symptoms had been present off and on for 12 years in one case, 10 years in two cases, 7 years in three cases, 5 years in two cases, 22 years in two cases, in two only nine months duration. Of these cases four had had melæna.

Of the 9 cases in which a definite diagnosis was possible, the pain came on more than two hours after food, or was said to have no relation to it. In six of these cases, the patient volunteered the statement that the pain was relieved by taking food, and that it woke him at night. In no case have I yet observed that the more solid the food the greater the ease. In all the patients in this group, there had been remissions of almost perfect health, and in several the symptoms had never been severe enough to make them

give up work. In many cases the pain was more to the right side than the left, but when dilatation of the stomach has supervened this is often masked by the symptoms due to this late complication. In one patient only, in whom the ulcer had been in existence twelve years, was there a history of jaundice, this came on three years after the commencement of the illness, and lasted a month.

Comparing these cases now with those of chronic gastric ulcer operated upon during the same period, cases in which the ulcer could be seen and felt. Out of 32 cases, 16 were women. In all except three the pain began within an hour of taking food, often within 15 minutes, and in all but two vomiting was a marked symptom, and relieved the pain. In 29 cases there was no suspicion that the ulcer had any other situation but the stomach. But in two cases a man of 42 and a woman of 37, the diagnosis was obscure, and

the suspicion was that it was doudenal.

II. S., æt. 44, was quite well until 2½ years before admission. He then noticed a sinking feeling in the epigastrium, followed by pain two and a half to three hours often food. This was a possible to the second transfer of the food. hours after food. This was relieved by lying down or taking a meal. This attack lasted six months, and then he had another of three months' duration, and free interval of five months, then an attack which lasted until admission. The pain was chiefly to the right of the midline, but when severe affected the left side also. He vomited on two occasions only.

had never had hæmatemesis or melæna.

He was a thin, rather sallow, man. The abdomen appeared normal, the stomach was not dilated, but there was a spot of deep tenderness one inch to the

right and above the umbilicus.

I considered this a case of duodenal ulcer. At the operation I found the duodenum perfectly healthy and free from adhesions, but there was a small saddleshaped ulcer on the lesser curvature of the stomach, midway between the pylorus and cardia. ulcer present and no scars. I operated December 2nd, 1908, and he went out free from symptoms on December 23rd.

In the next case, a woman, æt. 37, was admitted to hospital November 11th, 1908. At the age of 20 she had pain after food and vomiting; at the age of 22 she had hæmatemesis on one occasion. She then got almost well until the last three years, when she had been suffering from pain, coming on an hour and a-half after food, gnawing in character, and sionally waking her at night. The pain lasted till the next meal or until she took some sodii bicarb. No vomiting for years. Never any melæna. Has taken no meat or vegetables for years. In this case I diagnosed a duodenal ulcer, and thought that the original gastric ulcer had healed. The abdominal examination was negative.

The duodenum and anterior surface of the stomach were normal. On tearing through the meso-colon into the lesser sac, I came upon a hard mass the size of a shilling on the posterior wall of the stomach, close to the middle of the lesser curvature. I did a posterior no loop gastro-enterostomy, and she left hospital free

from symptoms 19 days later.

These two cases fall into the third group, in which the diagnosis between gastric and duodenal ulcer is impossible. Although a careful search was made, no trace of a duodenal ulcer was discovered. It must be remembered that these two conditions may co-exist, but, as Moynihan has pointed out, the gastric ulcer has usually healed. It must be a matter of great rarity for an ulcer to be diagnosed as gastric and turn out at the operation to be duodenal.

There still remains a group in which no symptoms indicative of a peptic ulcer exist; in these cases the patient is usually considered to be suffering from

gall-stones.

J. A., a Hebrew, æt. 30, was admitted to the hospital for attacks of pain, coming on irrespective of food, situated in the right hypochondrium, and of great severity. In addition to the sudden attacks of pain he had a constant pain in this region. He had never vomited or passed blood in the stools. He was sent to me with the diagnosis of gall-stones. The diagnosis evidently lay between this and duodenal

ulcer, and on the whole I inclined to the latter. At the operation I found a large mass in the second part of the duodenum, and did a posterior gastroenterostomy. He has now lost his pain and eats anything, but complains of some pain when he works.

In the next case the diagnosis was not at all evident.

H. P., a blacksmith, æt. 48, was admitted under my care, November 7th, 1908. For two years he had been suffering from epigastric pain, gnawing in character, varying in intensity, but gradually getting worse. It was not affected by food, never relieved by food, often waking him at night. The attacks lasted several waking him at night. The attacks lasted several hours, and during the last week the pain had gone to the right shoulder once or twice. Between the attacks he felt quite well. He eats anything, and had never had indigestion. He was a big, healthy-looking man. The abdominal examination was negative. I thought in this case that gall-stones was the most probable diagnosis.

On November 11th I explored and found the gallbladder healthy; on further search I found a hard mass on the anterior surface of the second part of the duodenum. I did a posterior gastro-enterostomy, and he left hospital free from pain and feeling quite well,

December 5th.

In both these cases the ulcers were in the second

part of the duodenum.

Passing the symptoms now in review. We can say that chronic ulcers situated in the first part of the duodenum can be accurately diagnosed in the majority of cases, that occasionally a gastric ulcer will be found where a duodenal ulcer was expected, that in all, the principal symptom is pain coming on a considerable time after a meal, often said to have no relation to food, at other times that it is relieved by taking food, often waking the patient at night. Vomiting is not a feature of the case unless the condition has led to dilatation of the stomach. Vomiting occurred in 11 out of the 13, but it was not a pro-Vomiting minent feature except in the cases I have mentioned. Difficulties arise in the cases in which the ulcer is situate in second part of the duodenum, or at the junction of the first and second parts. An effort should always be made to diagnose these cases early, and to investigate carefully every "dyspepsia" occurring in men of adult age, so as to avoid the desperate condition of perforation.

Treatment.—It appears probable that a duodenal ulcer does not heal except as the result of operation. If the condition is diagnosed, operation should be undertaken without delay. While in cases of chronic gastric ulcer, medical treatment should be thoroughly tried, I believe that it is useless when once a duodenal ulcer is present. Posterior gastro-enterostomy should be performed in the pyloric segment of the stomach, so as to preserve the normal functions of the stomach as far as possible. Gastro-enterostomy is an operation associated with very little risk. Since 1904, I have done sixty operations of this nature in simple conditions of the stomach without a death. Moynihan and Robson have recorded much longer series of cases

without a death.

The prognosis after operation is extremely good. I know of no condition, apart from chronic gastric ulcer, in which the relief is so striking, and the patients are free from those minor inconveniences which sometimes trouble after a successful gastro-enterostomy for gastric ulcer.

I have traced the after-history of all my patients. One case died, the first done in 1904. This patient died of broncho-pneumonia, five days after operation. This patient At the post-mortem examination, the anastomosis was perfect and the abdomen normal. The pathologist's diagnosis was "aspiration broncho-pneumonia."

Of the other cases, all have lost their symptoms, and in only one, the patient already mentioned, is there even discomfort. All surgeons report the same results. Mayo reported 175 operations with two deaths, of these patients he could trace 103, 93 of these were cured. Dr. E. B. Leech reports that of 6 cases of duodenal ulcer operated upon at Manchester Royal Infirmary, one died, and of the remainder, four were cured, one nearly so.

We have, then, in gastro-enterostomy a cure for duodenal ulcer, a cure which should not be left too

long before it is applied.

The question will arise as to surgical treatment during an attack of bleeding from a duodenal ulcer. Every case must be freated on its merits, no patient should be allowed a second attack of bleeding. I think that it rarely is necessary to operate during the attack, but if, in the opinion of those in attendance, the bleeding, if not rapidly arrested, will prove fatal, or the recurrence of the hæmorrhage be fatal, immediate operation will be advisable, and it may be necessary to open the duodenum and directly secure the bleeding point.

I have only been called in once to see a case in which there was severe hæmorrhage from a duodenal ulcer at the time of the bleeding in which the question

of immediate operation arose.

S. B., æt. 30, was admitted to a medical ward in the London Hospital, May 19th, 1905, with a history of ten years' indigestion. He had had many attacks of pain coming on two or three hours after food, sometimes accompanied by vomiting, but the vomiting never relieved the pain. He had never had any hæmatemesis, but his motions had been black. Three days after admission he was seized with an attack of giddiness, and passed 16 oz. of blood per rectum, and about the same amount on the following day. The next day he had another fainting fit, and then vomited blood. When I saw him the bleeding had ceased, and I dea large ulcer at the junction of the first and second parts of the duodenum. I did a posterior gastro-enterostomy, and he left hospital 28 days later. I saw him four weeks ago, fat, of a good colour, and without any pain or discomfort after food.

In conclusion, I would urge upon you the desirability of solutions and the colour is due.

bility of early diagnosis and early operation in duodenal ulcer, before serious complication such as per-

foration or bleeding occur.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Andrew Fullerton, M.D., F.R.C.S., Hon. Assistant Surgeon to the Royal Victoria Hospital, Belfast, and the Belfast Hospital for Sick Children. Subject: " Renal Calculus."

#### ORIGINAL PAPERS.

#### THE PREVENTION OF BLINDNESS DUE TO OPHTHALMIA OF THE NEW-BORN.

By N. BISHOP HARMAN, M.A., M.B.CANTAB., F.R.C.S.Eng.,

Lecturer in Ophthalmology, West London Post-Graduate College Assistant Ophthalmic Surgeon, West London Hospital; Ophthal-mic Surgeon, Belgrave Hospital for Children; Chief Clinical Assistant, Moorfields Hospital; Coulist, London County Council Blind Schools.

THE body politic, or the State, has done no greater honour to the medical profession than that which it has done in placing the national health in the protection of that branch of the profession controlling the public health departments. The recognition of the fact that modern medicine aims as much at the prevention of disease as at the relief of suffering is one of the greatest tributes that has been put to the credit of our art.

In these days we are as much in earnest in improving the physical possibilities of the children, and therefore of the race, as we are in the prevention of disease, for the one conduces to the other perhaps as much as the direct attack on the sources of infection. In all directions strenuous efforts are being made to improve the chances of happy and successful life for the coming generation, and the success that attends our efforts in guiding the energies of public-spirited lay workers to a fruitful result, will measure the degree of the continuance of the confidence that has been

reposed upon us by direction of the State in the many enactments that are written in the books of the law of civilised States.

Great things have been done, and yet much remains to be done. A very little acquaintance with certain of our public elementary schools will show that there are blots upon our success in the prevention of disease that should engage our earnest attention.

BLIND CHILDREN. For the past six years, by the direction of Dr. James Kerr, Medical Officer for Education of the London County Council, I have had the oversight of the Schools for the Blind and Partially Blind which form a part of the Special School system of the County. During that time I have examined over 400 children, noting the condition of their eyes, the degree of blindness and determining by every means in my power the cause of the blindness. The conditions affecting the eyes of these children are many, but by a very little arrangement it is possible to group them so as to show how heavy is the toll of blindness arising from certain

particular diseases. The figures which I arrived at and published recently in a little book, may be summarised as

follows: -

Inherited syphilis: (Interstitial keratitis, uveal disease, and optic atrophy)	6.36
Inherited syphilis:  (Interstitial keratitis, uveal disease, and optic atrophy) r  Optic atrophy, various causes	
(Interstitial keratitis, uveal disease, and optic atrophy) r. Optic atrophy, various causes	- 60
Optic atrophy, various causes	- 6-
	7.60
Macula damage	9.36
	1.38
Retinitis pigmentosa	1.38
Purulent ophthalmia	2,20
	0.82
Sympathetic ophthalmia	2.75
Trachoma	0.55
Phlyctenular keratitis	1.95
Congenital defects:	),
(Cataract, high myopia, microph-	
thalmia, buphthalmia, colobomata of	
iris and uvea, albumin, hydroce-	
phalus, etc.) 2	5-34
a effective and a second secon	0.27
<del></del>	

At the head of the list is the maximum percentage produced by one form of inflammation of the conjunctiva, and one that acts for only a very short period of the life of the subject. 36.36 per cent. of the blindness is due to the effects of the ophthalmia of the new-born

Great as this percentage is, it is in reality greater for, by careful attention and operation, some of the cases which figure in the list under those headings have been relieved to such an extent that they will escape from the category of blind; and then, by the exigency of official arrangements, the high myopes, who are not blind, but for whom an ordinary elementary school curriculum would be injurious, are collected in these schools. If all those who, in later years, would pass as bad-sighted, and not as blind, were eliminated, the percentage of blindness from ophthalmia neonatorum would exceed 40 per cent.

The figures obtained from the London County County

cil schools can be paralleled by those from any other country examined. Reinhard debited Germany, Austria, Denmark, and Holland with 40 per cent.; Claisse gave Paris 46 per cent.; Magnus gave Breslau 34 per cent.; and Katz gave Berlin 41 per cent. as blind from this cause.

INCIDENCE OF OPHTHALMIA NEONATORUM.

To obtain some indication of the incidence of the disease amongst the population generally, I have made two sets of inquiries: (1) A London district was selected, a suburb containing a fair average of London population. The practice in the district would be known as "Mixed." Half the population live in tenements, the other half in houses rented from £30 to £80 per annum, but there are few at the higher rental. At the lowest estimate, three-quarters of the children living in the district attend public elementary schools. I saw many of the doctors in private practice in this

neighbourhood and inquired their experiences of purulent ophthalmia in the new-born. I have now statistics of 15,000 live births. Amongst these the incidence of of injury to the eyes of infants from the disease averaged 0.047 per cent. Roughly, it may be said that of every hundred children born one contracts the disease and of every 2,000 born one is blinded or partly blinded by the effects of the disease. (2) As a check to this inquiry I examined the returns of the examination of the vision of children attending elementary schools in London, and found that one child in about every 4,000 showed the effects of the disease. It must be remembered in comparing the results of these two inquiries that no allowance is made for the death of affected infants, and according to Lobenstine and Harrar, of New York, children born of gonorrhœal mothers are less viable than those born of healthy mothers.

CENSUS OF THE BLIND.

In examining the Census returns of England and Wales for 1901, in a population of 32,527,843 souls, as many as 25,317 were returned as blind. Of these, 4,621 were returned as being blind from childhood, or one person in every 7,000. Of those blind from childhood, it is, of course, not possible to say with certainty the cause of the blindness, but those with experience of blind schools and asylums will not hesitate to agree that the conditions found in the London schools may be applied to the whole population. This would mean that in 1901 there were living 1,000 to 2,000 persons who were blind from purulent ophthalmia occurring at birth, and whose blindness

might have been prevented.

For a moment I might call attention to the seriousness of the loss which this means to the community. Let sentiment alone, and neglect the thought of the deprivation for so many of the chiefest joy of sense, and the greatest aid to freedom, usefulness, and pleasure. Consider only the cost of these damaged and the greatest and to treedom, userumess, and pleasure. Consider only the cost of these damaged folk to the community. Mr. Foulerton, the Medical Officer of Health for Surrey, in reviewing my book wrote:—"It may be pointed out that, accepting Mr. Harman's lowest estimate of 1,000 of the population blind from this cause, the cost of their maintenance must amount to over £50,000 per annum (the actual amount is probably nearly twice that sum), apart from the loss to the State of the services of so many workers." When we look into the accounts of the cost of providing education for the children in the elemenof providing education for the children in the elementary schools, and compare the cost of the normal child with that of the blind child, we are not surprised at Mr. Foulerton's estimate.

THREE CLINICAL POINTS.

I do not propose in this place to discuss the clinical aspect of the disease. Only on two points will it be worth while to revert to certain clinical features.

1. What is the cause, or most frequent cause, of the condition usually known as ophthalmia neonatorum? It is quite easy for anyone with a rudimentary know-ledge of bacteriology to satisfy himself of the com-moner infections that underly the purulent discharges of infants. For all practical purposes the micro-scopical examination of suitably stained film preparations of the pus form a sufficient diagnosis; and the conditions of staining are: that one be treated with an aniline dye such as Loeffler's methylene blue, and the other by the useful Gram's selective process.

A careful examination of large numbers of cases of purulent discharge in the new-born has shown that so per cent. are due to inoculation of the eyes at or about the time of delivery with the gonorrheal virus, the micrococcus of Neisser; and these are the cases that are dangerous to sight, for they produce the severest and most destructive form of inflamination, and consequently endanger the integrity of the cornea. The remaining 20 per cent. are cases of milder order, and are due to accidental inoculation with the Koch-Weeks bacillus, the colon bacillus, or the pneumo-As I have said, film preparations form a COCCUS. sufficiently accurate means of detecting these organisms in discharges from the conjunctiva.

2. Is the disease a danger to the members of the community other than the infants affected?

It is necessary to estimate the risk which these cases present to the community at large, for our view of the possible bearing of certain legislative enact-ments will be influenced thereby. It would be pos-sible to cite instances, and not rare instances of attendants on these children who have contracted the disease from their charges and whose sight has been seriously damaged thereby, but these cases are not talked of too much, they have a tragic side. Let me cite by way of evidence the following:-On one day at Moorfields Hospital I saw a mother and three girls, aged ten, eight and four years, and an infant of four weeks. The baby had developed ophthalmia neonatorum on the fourth day of life, a week later the youngest girl contracted the disease, a few days later the second caught it, and subsequently the eldest girl; and at the time they were seen the four children had the disease, and the mother showed the initial symptoms of an attack. Further, it was found that each of the children suffered from a gonorrhœal vulvitis. Such a series of secondary infections demonstrates more forcibly than any argument the risk of such a disease to the community at large.

3. What class of the population are most affected by the disease? I can best answer this by giving my experience at the Belgrave Hospital. For many years it was situated in Pimlico, and tended a small but very poor district. Amongst the infants under the age of 12 months, 34.4 per cent. were suffering from the ophthalmia of the new-born. In the new hospital at Kennington the patients are more numerous, and, on the average better kept. Of the infants under the age of 12 months that have attended here, only 6.2 per cent. were the subject of the disease. It is evident from these figures poverty and neglect tend to increase

the liability to the disease.

PREVENTION OF THE DISEASE.

Long before the microbic origin and the essential contagiousness of the disease had been determined, some sage observers came to conclusions as to its nature, and the precautions to be taken for its preven-

tion, that cannot be bettered to-day.

To Gibson, of Manchester, belongs the credit of first pointing out what should be done to stay the ravages of the disease. He wrote in 1807, giving three directions :

(1) The leucorrhœa of the mother ought, if possible, to be cured during pregnancy.

(2) When this has not been done, the noxious secretion ought to be removed from the vagina during delivery.

(3) The infant's eyes ought, immediately after birth, to be cleansed with a fluid which either removes the noxious matter, or is able to prevent its injurious effects.

No directions could be better. many would not believe in the true contagiousness of the disease. Stellwag, writing in 1860, recommends, for the prevention of the disease, "to keep the child away as far as possible from all dazzling light."
Cleanliness is of little count in his mind, and he repudiates the idea of inoculation from maternal discharges. The discovery by Neisser of the organism responsible for the most serious form of the disease justified Gibson and his preventive methods, and thenceforward there came the general introduction of regular practices of cleansing the passages of the

mother and the eyes of the child.

The name of Credé is particularly associated with the modern practice of prophylaxis. In his earliest publication he lays stress on the necessity for the dis-infection of the vagina, and the subsequent cleansing of the eyes of the child with an antiseptic solution. Gradually attention became focussed on the child's eyes. That the organism in question could be easily destroyed was shown by Piringer. He found that pus from an acute case of the disease might be inoculated into the conjunctival sac without injury, provided it was well washed out with water not later than three minutes after the inoculation.

Credé ultimately recommended the instillation of a 2 per cent. solution of silver nitrate into the eyes of the child immediately after birth. The benefit of the measure as applied in certain lying-in institutions is

beyond doubt. In Credé's clinic in Leipsig, prior to the use of this prophylaxis, the average incidence of the disease was 10.8 per cent.; after its use the incidence fell to between 0.1 and 0.2 per cent., and under similar conditions as good results have been obtained

Such results as these are very striking, and it is no wonder they have elicited much enthusiasm from those who know how much of the blindness found in our asylums is due to this one disease. From the recognition of the boon such a method may be under certain conditions, it is but a short step to suppose that it could be of equal value were it carried out under all conditions. Accordingly, it has been proposed that the method of Credé should be made compulsory by law-that is, that the eyes of every child should be treated with silver drops as soon as it has been born.

Such a proposition as this could not be made without exciting discussion, and there has been plenty of it, both at medical society meetings and in the medical

To sustain an argument for compulsory prophylaxis, two points must be made:-

(1) That there is a general or fairly general liability to the disease.

(2) That the prophylaxis is a certain preventive of the disease.

The first proposition is absurd. It can only be held by men who work so long at certain classes of disease that they become so obsessed by the disease that they consider all contaminated thereby. But the disease is not like small-pox, to which all unprotected are liable, be they clean or dirty, moral or immoral. It has at least for 80 per cent. of the cases a basis which proves a breach against the ordinary canons of morality held by the community. To brand the whole community because of a relatively few sinners would be as absurd as to damn with faint praise the pleasant lake of Windermere because we find on part of its leeward shore a filthy scum of froth and rotting weed and

But let us take a few figures. Of the 15,000 London births of which I obtained information privately, 12,000 were delivered by doctors who used no other prophylaxis than scrupulous cleanliness, and left silver or mercury solutions for the suspect cases. The incidence of the disease amongst these children was 0.72 per cent., and the injury rate 0.04 per cent. This compares very favourably with the best Leipsig results when Credé's method is practised.

As to the second proposition, the efficacy of the prophylaxis, we may admit that the use of silver nitrate drops of 2 per cent. is effective in cases where they are properly employed, but the usage may occasionally do direct injury to eyes, and, again, it may only cover slovenly practice.

There is a distinct body of evidence to show that

the use of the silver solution, or, for that matter, any germicide of sufficiently powerful effect, is not always innocuous to infants. Any such re-agent by its very nature is an irritant, and is liable to produce a transitory inflammation of the conjunctiva; this is a small matter when the effects are watched by skilled observers, but it would not be so if the usage became so prevalent and were placed in the hands of untrained, or partially trained, midwives; they would be likely to mistake the "silver catarrh," as it is called, for an initial sign of ophthalmia neonatorum, and probably increase the mischief by a further use of the germicide. I have seen this done, and with serious effects in weakly and ill-developed children.

Of the 15,000 private cases I have referred to, 3,000 were treated by the full Credé method, yet there were 1.2 per cent. of mild purulent cases, and o.1 per cent. of severe purulent cases, and in two cases, or 0.06 per cent., eyes were blinded. The figures for these 3,000 cases are not so good as were those of the other 12,000 of the same district where there was no routine use of germicides.

From these observations we may conclude: That Credé's method has done wonders in reducing the incidence of ophthalmia neonatorum in lying-in institutions, but it has not extinguished the ophthalmia, though the method is applied by experts and the

infants are under complete control. Further, special routine methods may be necessary in hospitals where there is a cumulation of sources of infection. experience of private practitioners, men who have carefully tried both methods, prefer strict cleanliness to a routine use of a germicide, reserving the germicide for suspicious cases; and in this they are following the dictate of rational medicine, and also the lines of prophylaxis, first suggested by Gibson.

At this point I might outline a course of procedure

for those who like rules.

1. Directly the head of the infant is born, wipe the eyes dry with clean, dry cotton wool.

2. As soon as the mother is settled, wash the eyelids of the infant freely with a simple lotion, then part the lids and run plenty of the clean fluid between them. For midwives, Condy's fluid is best, for the colour is impressive. The water used in the first bath of the child must not get into the child's eyes. At no time during the lying-in period may the mother's sponges,

napkins, etc., be used for the child.

3. If at delivery there be a suspicion of a purulent discharge from the vagina of the mother, cleanse the eyes in the same way, and wash thoroughly, then instil a drop of silver nitrate, 2 per cent., between the lids. The eyes must be re-examined and washed at the end of eight hours, and if there be any suspicion of discharge instil silver nitrate of r per cent., and no stronger, once in twelve hours, and wash with Condy every three hours. I lay as much stress on the washing as on the use of the germicide.

Recently an experienced lady doctor, a supervisor of midwives, asked me how I defined a "suspicious discharge" in infants, seeing that in most pledgets of mucus appear at the inner canthus by the end of the first twenty-four hours. My answer was to quote the words of the memorial to the President of the Local Government Board in 1884:—"If the child's eyelids become red and swollen, or begin to run with matter. . . . "

#### NOTIFICATION.

It is not enough to leave the matter here. Our present methods, even with the aid of the Notification of Births Act, do not give us effective control over the disease. It is still appallingly common to get children brought to the eye hospitals with the eyes irretrievably damaged within the first month of life.

Compulsory notification of ail cases has been suggested as the best means of controlling the disease. The idea is an excellent one. This manner of attacking a disease is not new and unfamiliar; it has the advantage of custom and use. Some diseases must be notified at all times; others are added or removed from the list as occasion and epidemics suggest. The Infectious Disease (Notification) Act of 1889 has worked with conspicuous success in the case of those diseases scheduled under the Act, but the ophthalmia of the new-born is not amongst them.

Notification of a disease is one of the first requisites to our knowing what is the true incidence of the disease. The tale of its effects we may know, but the number of cases from which these arise we do not know. So those who look to the compulsory use of a germicide must urge the necessity for notification as a preliminary to their demands.

I can best illustrate the advantages to be derived from notification by the following:—
In a series of 60 cases of ophthalmia neonatorum, 22

were first seen by me three or more weeks after the onset of the disease; of these 18 came with one or both eyes permanently damaged. The other 38 cases were seen in the first week of the disease; only one suffered any permanent injury to the eyes, and in this instance the parents lived twenty miles from the hospital and failed to bring the child for attention. The moral is clear—get the cases early and treatment will be a brilliant success. This is why we desire compulsory notification.

Notification is not only a controlling measure, it is of the highest educative value to the general public. It brings home to those most interested the seriousness which is attached to the disease by the authorities, and it is an infinitely preferable mode of education to such

wild-cat schemes as that proposed by Fieuzal, of Havre—that a booklet with warnings of the dangers of the disease should be given to those registered as just married; or the even more appalling proposition of Cohn—that the dangers of the disease should be explained to children in schools!

There are two objections to notification that I may

deal with here:

That the disease is essentially venereal, and that notification of the occurrence of the disease would be a hint of the "C.D. Acts." This objection disappears entirely when we remember that 20 per cent. of the cases of purulent conjunctivitis in the new-born are due to organisms other than the gonococcus. It is true that this is the most frequent and most dangerous

cause of the disease, but there are others.
2. The Infectious Disease (Notification) Act was drawn up, it is sometimes said, with the intent of protecting the public, and not to secure for the sufferers prompt treatment. The history of the family I have given, where the disease of the baby was communicated to the three elder girls and then to the mother, and ultimately produced a vulvitis in all the girls, is sufficient answer to that objection. The disease is essentially contagious, and is a danger to the community. It may not kill, but it certainly blinds.

#### SUGGESTED SCHEME.

Happily, no fresh legislation is necessary to make ophthalmia neonatorum a disease which must be notified. Under the powers of the Act of 1889 every local authority is enabled to add to the list of diseases the occurrence of which must be notified to it, subject to the consent of the Local Government Board. power has been fully used, and is increasingly taken advantage of.

The next concern is the machinery available for the treatment and oversight of the cases that may be notified. Here the difficulty is great owing to the overlapping and lack of co-ordination of the many health lapping and lack of co-ordination of the many health authorities. The medical officer of health of a district may not treat cases himself, but if he cannot do it directly, he can influence it indirectly. He can require the certification by a medical man that the case is being so treated as will prevent its being a danger to the community; and, failing that assurance, he could probably deal with the case as he would with a case of infectious fever—require the removal of the case of infectious fever-require the removal of the patient to a proper hospital or infirmary.

In the Midwives Act of 1902 we have already con-

trol in theory over a large number of those who conduct confinements; and as time goes on this control will be more effectual; but so far the arrangements do not permit of the oversight of cases occurring in their

Briefly, we should aim at:-

1. An exercise of the powers of the local sanitary authorities under the Infectious Disease (Notification) Act of 1889, to proclaim all cases of purulent ophthalmia occurring in children within twenty-one days of birth, notifiable by the attendant in whose knowledge they come, under penalties provided in the

2. The arrangement of such a plan as will enable the case to be promptly diagnosed by a medical officer skilled in the bacteriology of the disease: also to enable the case to be promptly and efficiently treated, ether by a private doctor, or by a doctor or doctors deputed by the Midwives Supervision Boards, or by a public hospital; or, failing these, to provide for the removal of the child to a Poor-law infirmary or such other convenient place as may be arranged, the mothers being provided for within the hospital for such time as necessary.

That the results of all such cases on the cessation of the disease should be notified to the medical officer of health for the district, for return to the Local Government Board, and subsequent publication with

the returns of infectious diseases.

I believe the working out of such a scheme as this would result in the almost total extinction of blindness due to purulent ophthalmia at birth, both by ensuring the prompt and efficient treatment of all cases of the disease, and also by educating the public to a sense of the seriousness sibility in the matter.

Conclusion. of the seriousness of the disease and their own respon-

In conclusion, I would urge the necessity for speedy action in this matter. With the extension of the Employers' Liability Acts, it will be increasingly difficult for the physically defective to obtain employment. Contracting out by the employers is not permitted, and the risks of employers are proportionately increased when a workman suffers so grave a physical defect as that of blindness. The scope of useful and remunerative manual work for the blind of ordinary ability is not wide, and there is difficulty even now in meeting the need satisfactorily. With the risks of employers liability pressing so heavily, the prospect of employment being found from philanthropic motives will steadily diminish, so that in some way or other the burden of support of the blind will fall on the State, either by the necessity for the provision of special workshops for them, or else by their drifting destitute and helpless on the poor relief funds. Public opinion would scarcely tolerate this latter condition, if the State by the extension of the employers' liability hinders the continuance of philanthropic effort which has been so successful in the past, the State will be compelled to take up the burden it has made impossible for private effort.

With such a prospect in view, it is indeed necessary for the State, if only from mere pecuniary motives, to do all in its power to prevent the occurrence of blind-

ness which is preventable.

# THE TREATMENT OF VARICOSE VEINS OF THE LOWER LIMB BY INTRAVENOUS INJECTIONS OF IODINE.

BY PROF. B. SCHIASSI, M.D., Surgical Tutor to the Faculty of Medicine of Bologna. [SPECIALLY REPORTED FOR THIS JOURNAL.]

In operating on varicose veins in the lower limb, I have often asked myself whether it was not possible to discover a means of dispensing with the necessity for the multiple incisions and innumerable ligatures

entailed by surgical intervention.

It has occurred to me that this might be done by turning to account an ancient practice which had for object to bring about the obliteration of the varicose veins by means of a chemical action provoked by substances introduced directly into the dilated vessels. But, before elaborating this idea, I had to dispose of the objection that has been raised to the principle involved in this mode of treatment—viz., that oblitera-tion of the veins thus induced by a process of thrombosis exposes the patient to the risk of the de-tachment of an embolus which may find its way into the general circulation and inflict irretrievable damage on some vital organ.

Personally, I am disposed to regard this risk of embolism as purely hypothetical. So far as I am aware, not a single instance in which a fatal embolus has been set free as the result of chemical phlebitis of a superficial vein has been observed, and, until it has actually occurred, I hold that it is extremely unlikely to happen, because, when we determine the chemical obturation of a vein by the irritating action of a non-necrosing agent, the obliteration takes place by a slow, gradual process of endothelial irritation followed by an increase in the number of young connective tissue cells which by-and-bye become adult and permanent. Under these conditions, the detachment of an embolus is hardly conceivable. Moreover, when we are dealing with the lower limb, the hydro-dynamical conditions in which the superficial venous pleaus of varicose subjects are placed, cause the circulation to be slowed down, and are distinctly unfavourable to the ascending displacement of embolic dibris. This argument is the more cogent seeing that Professor Bier, in some thousands of cases of varicose veins of the leg, thrombosed or not, has induced very active hyperæmia without having ever witnessed the slightest embolic manifestion.

Even if we admit, in the face of the evidence, that chemical thrombosis may give rise to embolism, the method of treatment employed by me provides an effectual guarantee against its occurrence, and need,

therefore, excite no apprehension.

Of the substances at my disposal I have selected the most irritating and the least toxic-viz., iodine. based my choice on experiments carried out by various observers, and on observations of my own on the intra-venous injection of iodine, previously undertaken with another object in view, which convinced me that it was likely to produce the effects I desired.

My procedure is the following: Having anæsthetised the skin by the injection of a few cubic centimetres of novocain, or under the influence of intraspinal anæsthesia, I make an incision two or three inches in length above or below the femoral condyle, accordin length above or below the remoral condyie, according to circumstances, and expose the saphena vein to that extent. This I ligature at the upper part of the wound, and at the lower angle I apply a pressure forceps to the vessel, which is then cut through near the ligature. This gives me an inch or an inch-and-a-half of vein. An assistant seizes the gaping vessel with a pair of forceps, and introduces a small glass the with a polivary and this is tied in position. tube with an olivary end. This is tied in position, and is joined at its free end with a piece of rubber tube, into which a large glass syringe is inserted. This syringe is previously filled with the following solution of iodine:

Iodine, 16 gr. Potassii iodidi, 23 gr. Aquæ dest sterilis fl. oz. iiiss.

The syringe having been joined up, the blood is allowed to invade and entirely fill the glass and rubber tubes in order to avoid the introduction of air bubbles. The injection is then made rather slowly, and directed towards the extremity of the limb. The injection is repeated until we have introduced from 30 to 50 c.c. (about an ounce and a-half) of the solution, according to the number and size of the varicosities and the dimensions of the limb. Then the vessel end is tied just below the glass tube, the end is cut off, and the small cutaneous wound is closed with two or three sutures.

As a rule, the patient does not complain of much pain during the intravenous injection of the iodised solution, though some subjects experience a burning sensation in the injected limb. When this is the case, the sensation may be obviated by injecting a solution of novocain, 25 per thousand, beforehand, but, in any case, the disagreeable feeling only lasts a few minutes.

I have never witnessed any disturbance, either local or constitutional, immediate or delayed, as the result of such injections, when practised of the strength and in the manner I have laid down. At most in the course of two or three hours the patient may present a slight rise of temperature (101-102.5° F.), and this subsides in a few hours.

The iodine injected infiltrates the whole of the superficial veins of the leg as far as the malleoli; a small quantity, indeed, passes vid the communicating veins

into the deep veins.

It is hardly necessary to describe the histological changes that take place in the walls of the veins consequent upon contact with the iodine, these having been thoroughly investigated by many authors. The interesting clinical fact is that six or eight days after the injection the greater part of the veins through which the iodine has circulated are transformed into hard cords perceptible on palpation, and are completely and finally obliterated. It follows that the passive hyperæmia which obtained in the domain of the superficial circulation of the leg is abolished, and varicose ulcers and eczematous patches due to the embarrassed local circulation improve and cicatrise.

This method has at any rate the merit of simplicity, and I term it the "minor means," because, by a very

and I term it the "minor means," because, by a very trifling operative act, we obtain a very striking result. I am convinced, as most of us are at present, I imagine, of the accuracy of Verneuil's theory of the deep origin of varicose veins, but in many cases it is necessary to get rid of the passive hyperæmia of the superficial plexus of veins in the leg, since this greatly assists the deep circulation. For instance the force assists the deep circulation. For instance, the force

which pushes the blood upwards, instead of being divided between the superficial and deep circulations, once the superficial circulation has been remedied, is wholly directed to the deep circulation increasing the rapidity of the flow, and preventing passive varicose

hyperæmia.

It is hardly necessary to remark that this treatment will not cure all cases of varicose veins, old-standing ulcers, and chronic thrombosis; indeed, it does not appear to me likely that any one method of treatment can prove successful in these various conditions. As, however, I have applied the method in some sixty cases, and have since been enabled to follow up the patients, I can recommend it with confidence.

#### STREPTOTHRICOSIS: WITH SPECIAL REFERENCE TO THE ÆTIOLOGY OF MYCETOMA. (a)

BY PROFESSOR MUSGRAVE, M.D., M.CH.

AND

MR. M. T. CLEGG.

BEFORE entering on a study of the ætiology of mycetoma, it is necessary to define the disease. is exceedingly difficult, either from a clinical or an ætiologic standpoint. Formerly the diagnosis was based upon a clinical picture the essentials of which were a chronically enlarged foot with sinuses from which were discharged small granules of various colours and consistency, accompanied by a peculiar oily degeneration of the tissue. However, when bacteriologic studies began to show the multiplicity of the organisms concerned in the production of Madura foot it became necessary either to consider it a "clinical" entity of "multiple" ætiology or to attempt an "ætiologic" classification. This was made still more imperative by the discovery that the organisms causing this symptom complex were found also producing lesions in other parts of the body. A number of authors have continued to use a clinical classification, while others have attempted to give one based upon ætiologic findings. The result is great confusion in the nomenclature of the disease. Authorities differ as to where the group of organisms belongs in the vegetable kingdom, some placing it among the bacteria and others higher up among the fungi. Practically all the latest writers upon the subject agree as to the great similarity between the various species of these organisms and the majority have placed them as species of a single genus, or as parts of two or even three closely allied genera. In order to establish a uniform and clear conception, and after carefully studying all phases of the question we have decided tentatively to accept 'Streptothrix' Cohn 1875, as the generic name of the group of organisms under discussion.

THE DISEASE DEFINED.

Mycetoma may be defined and classified in one of three ways, if "Streptothrix" is accepted as the most available generic name.

(I) It may be considered as a clinical disease of multiple ætiology (which may or may not be limited to "Streptothrix" infections); (2) the term may appropriately be made synonymous with streptothricosis. actinomycosis, nocardiosis, etc.; (3) it may be made a clinical type (foot infection) by a "Streptothrix (Actinomyces or Nocardia")." Each of these classifications has something in its favour and also may be criticised. The first would make diagnosis easy, for all forms of foot enlargement giving certain clinical manifestations regardless of the ætiology, known or unknown, might be included, but it is open to the objection of not being definite and does not conform to our present methods of ætiologic classification. The second method has much in its favour and is practically adopted by Manson. The objections to it are that it adds a new significance to a term which does not clearly express

<sup>(</sup>a) Abstract of Paper read at the Bombay Medical Congress, Feb. 25th, 1909, in reference to "Schemes for Sanitation in India."

the conditions and also adds a further synonym to a group of infections already rendered confusing by the number of its synonyms. The difficulty can more

the number of its synonyms. The uniform more satisfactorily be met by the third method.

We have therefore decided to follow the third classification making mycetoma a "clinical" type or variety of streptothricosis—"Streptothricosis pedis" —and to define it as follows: A disease consisting of a "Streptothrix" infection of the foot ("Streptothricosis pedis, Actinomycosis pedis"), characterised by a chronic course, swelling and deformity of the part, a peculiar, oily degeneration of the tissues with cavity and sinus formations and the discharge through the fistulous openings of mycotic aggregations containing the micro-organisms. Mycetoma, with this definition, becomes so intimate a part of streptothri-cosis that a balanced conception of it can only be obtained by a study of the whole subject of streptothricosis and a classification of the organisms concerned. For this reason, the scope of this paper has been enlarged to include a discussion in two parts of the whole subject of "Streptothrix or Nocardia" infections.

#### SPECIES DETERMINATION.

Following the generic name of the entire group of organisms under consideration, the next logical step of the problem is a discussion of the species properly belonging to the genus. The classification of species is a more difficult problem than the generic determination, largely because of the imperfect description of many of the so-called species or varieties. In fact, but few have been described with sufficient

clearness to make determination possible.

If we carefully study the literature of species determination, it will be found in greater part to be only of historic interest and value. The work is generally too incomplete to be final for species determinations, and in cases even the generic position of the described parasites is doubtful. For this reason we have considered only the technical descriptions of the organisms which have been cultivated and described with sufficient accuracy and completeness to make them available for comparative purposes. Much of the work of the older writers was well done when due consideration is given to the technique developed at the time of publication, and this work should always be kept before us in giving historical summaries. Many of the articles in the literature are incomplete, and a careful study of such descriptions as are given convinces us that not more than ten different species are represented in the group. Several of the varieties may show slight morphologic and biologic differences, but these are not sufficient to warrant their being classed as separate species.

DISCUSSIONS AND CONCLUSIONS.

The subject of streptothricosis or nocardiosis becomes somewhat simplified if the results of our own work are combined with those taken from the litera-ture, but we realise fully that after considering all possible evidence, points must still remain open for discussion, and complete harmony regarding this subject can only be obtained by common adoption of a somewhat arbitrary classification.

It is difficult to determine upon the correct name of the disease, because of the botanical confusion regarding the position and designation of the group of organisms concerned, and of the lack of clearness of definition specifying definite limitations for the organisms to be included as the ætiology factor.

Whatever the nomenclature, it is a fact that we have here a group of closely allied vegetable parasites of man and animals, which have the following principal characteristics: Branching, filamentous organisms which develop into colonies made up of the organisms and "transformation products." The terminal hyphæ may or may not be radially placed on the surface of the colony and they may or may not develop "clubs." The group in general take Gram's stain and several members show acid-fast properties in a varying degree. The organisms grow on artificial media, differing in their requirements for oxygen and in pigment productions. To a less degree they show other variations in appearance on artificial media. The majority of the organisms produce lesions in monkeys, which histologically resemble those found in the human infections and in those of other animal diseases caused by members of this genus.

There is, in human pathology, a very important group of branching, filamentous micro-organisms which logically belong to a single genus. The generic name is variously given as "Streptothrix, Actinomyces or Nocardia"; the last of these names is probably scientifically the most correct, but because of the present botanical confusion and uncertainty of the present botanical confusion and uncertainty the first is here employed because of its more general acceptance.

#### IMPORTANT SPECIES.

The following species, to judge from our work and from a study of the literature, are the most important and may be recognised as established. (There are probably a number of others, but the description of many of them are too imperfect to allow of their recognition):—"S. actinomyces," Bostroem, 1850; "S. actinomyces," Wolff and Israel, 1891, and Wright, 1905; "S. nocardii"; "S. eppingeri"; "S. madura"; "S. capræ" Silberschmidt.

The disease caused by infection with these parasites is properly named streptothricosis, with actinomycosis and nocardiosis as synonyms. Other names, such as lumpy-jaw, madura foot, mycetoma, etc., should be considered more as describing anatomic location rather than as designations, relating to any special or specific cause of infection. Mycetoma might well be taken as the correct name for the group of infections if a strict interpretation of rules of nomenclature is followed, but usage renders it perhaps more desirable to retain the name as representing "Streptothricosis pedis." If mycetoma is to be considered in any more comprehensive light than this, it should become another synonym for streptothricosis. It should not be considered a disease caused by organisms other than "streptothrica."

#### CHARACTERISTICS.

Streptothricosis is an infectious disease of man and animals caused by one or more species of "Streptothrix." It is characterised anatomically by a peculiar low grade of inflammation, usually confined to one part of the body, but in rare instances assuming the proportions of a general infection. The inflammatory process usually is accompanied by suppuration of a certain kind; the discharges contain granules made up principally of colonies of "Streptothrix." The general picture of chronic inflammatory disturbance is seen clinically, and enlargement, suppuration and the presence of the causative organism in the lesions is observed locally.

The diagnosis of "Streptothrix" infections is made clinically by the character of the exposed lesions and discharges and by laboratory methods. Obviously, the common and frequent involvement of internal organs is rarely recognised except by microscopic examinations at operations or at autopsy. The thoracic types may be determined by microscopic and bacteriologic studies of the sputum or aspirated fluid from the pleural cavities. It is generally stated by competent observers that these types are frequently overlooked, even in sputum examinations and it is not improbable because of the acid-fast properties of some of the organisms that they may occasionally be mistaken for the tubercle bacilli.
The resemblance may, at times be quite close. In some of our experimental lesions the similarity has been striking. The microscopic examination of material from exposed lesions often requires some patience and care to enable the observer to find the been striking. organisms; unless a granule is encountered, when, of course, the determination is easy. Inasmuch as some other closely related organisms such as "Oidia, Leptothrix and Cladothrix" may cause somewhat similar lesions, "Streptothrica" should not be diagnosed positively without careful microscopic study of the organisms present in the lesions.

PROPHYLAXIS AND TREATMENT.

Prophylaxis.—From what we know of the distribution of the organisms of this disease and the mode of transmission and the prevalence of certain anatomical types, prophylaxis should consist in guarding against wound infection and generally by care in food and drink. In the Tropics most of the types consist in local foot or other skin wound infections, which should be guarded against by wearing shoes and by promptly treating skin wounds and abrasions accord-

ing to antiseptic methods.

Prognosis.—The prognosis depends to a considerable extent upon the location and extent of the lesions. The general infections and those of the internal organs almost always end fatally. The external types are much more amenable to treatment and the mortality is small. According to the statistics of Duvan, and Poncet and Berard who analysed 257 cases, the mortality was as follows: Skin 2.3 per cent.; face and neck, 10; jaw and temporal region, 30; abdominal cavity and intestine, 65; thoracic, 85; liver, 100; and brain and spinal cord, 100. The mortality in mycetoma, under proper treatment, is very small. The course of the disease is usually chronic, but it may be general and acute, and general infection may take place during the course of a chronic localised type of the infection.

Complications.—While streptothricosis may be found together with a number of other diseases, or may develop its symptoms as sequels of other diseases, the principal direct complications are those due to mixed infections of bacteria. Several of the pathogenic bacteria have been found associated with "Streptothrica" in lesions and the course and outcome of the disease is influenced accordingly. Tuberculosis, because of its close clinical relation to streptothricosis and the frequent lung involvement of both organisms, has led to confusion in some of the reported cases.

Treatment.—The varieties of treatment most useful in this disease are general, as well as local surgical intervention, if cause is indicated and a combination of all these methods may be necessary. Potassium iodide administered in large doses over a long period of time is generally admitted to have a favourable influence on the course of the disease and complete cures have been reported from this method of treatment. Local measures consist in antiseptic dressings and the use of the Rontgen rays. Surgical measures consist in drainage, removal, or amputation according to the location and extent of the lesions. A combination of all three forms of treatment would suggest itself as offering the most favourable opportunity for recovery.

#### CLINICAL RECORDS.

NOTES OF

TWO CASES OF "PURPURA HÆMORRHAGICA"
TREATED WITH POLYVALENT ANTI-STREPTOCOCCIC SERUM. (a)

By J. A. COUTTS, M.B.CANTAB., F.R.C.P.

As an addition to the cases of recently reported purpura, brief notes of the two following ones may be of interest. The classification of cases of purpura is still unsettled, and more or less in a state of chaos. The ætiology, too, in a majority of cases is equally uncertain. Especially is this last the case in dealing with so-called "purpura hæmorrhagica," taking this title in its widest definition, as including all cases where hæmorrhage into the skin is complicated with bleeding into deeper parts. The more usual sites for these internal hæmorrhages are the gastro-intestinal track or some part of the urinary system, but in cases with an identical affection of the skin bleeding may occur into the pericardium, the lungs, the brain and its meninges, the joints, and numerous other situa-

(a) "West London Medico Chirurgical Journal," September, 1908.

tions. The prognosis in "purpura hæmorrhagica" is as uncertain as the ætiology is obscure, but in cases of any severity the mortality is far from inconsiderable. A recent theory that some of these cases of "purpura hæmorrhagica" are of microbic origin is receiving increased support, and the theory is strengthened by success in treatment based upon it. (a) If further experience should confirm the success of this treatment, then its adoption marks a distinct gain in therapeutics.

A. O., æt. 3½, was admitted into the East London Children's Hospital on February 24th, under my care. A week before (Monday, February 17th) the mother noticed "spots and bruises" on the back, and the following day these "had spread all over him." Three days after the first appearance of the spots bleeding occurred from the mouth, gums, and nose, and one day later the water contained blood. There had been no vomiting, and there was no complaint of pain in joints or abdomen. The child had never been ill before, and the family history contained nothing of

interest.

On admission the patient was a well-nourished child, but blanched from hæmorrhage and apathetic. His face, body, and limbs were thickly covered with purpuric spots of medium size, and there were some larger bruises in one or two regions. The more recent spots were bright red, and the older ones were undergoing the usual changes in colour. The mucous membranes, lips, gums, and eyelids were extremely pale, and there was some slight hæmorrhage on the surface of the tongue. There was a well-marked hæmic murmur at the apex of the heart. The motions were normal, but the urine apparently consisted of little but pure blood. A blood examination showed Hb. 35 per cent., red cells 2,500,000, white cells 6,000. The temperature which was 98.4° F. on admission, fell to normal the same night, and did not rise above normal again. The case was unmistakably a severe one and the prognosis grave. The child was put on 5-grain doses of calcium lactate every four hours, and a rectal injection of 10 c.c. of polyvalent anti-streptococcic serum, three of these injections being given altogether at intervals of two days.

Two days later, February 26th, the child was much better; one or two fresh purpuric spots have appeared on the abdomen, but the rest of the eruption is failing. The urine is no longer bright red, and contains much

less blood.

A week later, March 4th, the urine contained no albumin, and showed no trace of blood by the guaiacum test.

March 8th: The child is now quite well and the

purpuric eruption entirely disappeared.

M. S., æt. 13, was admitted into hospital on March 2nd, under my care. Five days previously, February 27th, he complained of pain in his right leg from the knee downwards. Two days later, February 29th, a red patch developed over the right elbow, and there was pain and swelling of the joint. The next night, March 1st, the left elbow became similarly painful and swollen. In addition to that in the swollen joints there was pain over the body generally, not especially severe in abdomen. There was no history of hæmophilia or bleeding from gums or elsewhere. On the day of admission the boy was seen, in the surgical out-patient department, by one of my colleagues. There no diagnosis was arrived at, but the patient was sent in with the suggestion that the case was possibly one of some form of epiphysitis.

On admission the patient was a fairly nourished lad. Both elbows were swollen and painful both to pressure and passive motion. On careful examination in a good light there seemed to be some infiltration into the skin around the elbows, and on the right some very slight discoloration like that of a fading bruise. It was considered that the joint effusions were probably hæmorrhagic, and an exploratory needle inserted into one drew off only a slight quantity of blood. There were no other cutaneous

<sup>(</sup>a) Soltau Fenwick and Porter Parkinson, "Med. Chir. Trans.." London, vol. lxxxix., 1906.

hæmorrhages, and the urine contained neither albumin nor blood. The temperature was normal and the leucocyte count 9,000. As one of my colleagues considered the proof of the value of the neither serum treatment in the former case was discounted by the fact of the simultaneous administration of the doses of the last drug, every four hours, and the serum temporarily withheld. A week later, March 9th, the patient was worse. The swelling of the elbows had disappeared, and there was some discoloration, like that of a fading bruise in the neighbourhood of each joint. A cutaneous swelling had developed over the left forearm, and both hands were puffy and swollen. The day before swellings, which were taken to be hæmatomata, had appeared in the scalp over each parietal bone. These quickly in the scalp over each parietal bone. These quickly invaded the whole side of the head, thrusting the ear before them on both sides. There were a few small purpuric spots on the side of the nose, and some larger ones dotted sparsely over the lower extremities. For the last two days there had been abdominal pain and the motions contained a considerable amount of dark blood. The calcium lactate was then dropped, and the boy given a rectal injection of

20 c.c. of anti-streptococcic serum.

The further progress of the case can be briefly summed up. The hæmatomata speedily resolved, and the swellings over the left forearm and hands disappeared, leaving faint, bruise-like stainings. About week after the injection the boy had a return of abdominal pain, and a trace of blood reappeared in the stools. He was then given a second rectal injection of 20 c.c. of the serum. After this he had no further trouble, and his progress to recovery was uninterrupted. About ten days, however, after the first rectal injection a profuse coppery-coloured eruption developed, mainly around the ankles and the elbow-joints. My colleague, Dr. Graham Little, who kindly saw the case for me, was inclined to regard this as a manifestation of the original disease, but I attributed it to the effects of the serum, the rash from the last being modified perhaps by the boy's tendency to purpura. It gradually faded without taking on the hæmorrhagic character of the previous purpura

These two cases in themselves prove little, but they are at least confirmatory of the excellent result of the serum treatment of purpura hæmorrhagica in the hands of others. I used the anti-streptococcic serum mainly because, as far as I know, it is the only one that has been tried with success in such cases. It is quite possible, however, that other forms of sera would prove equally efficacious. Such interesting results, indeed, are now being obtained in numerous conditions by the use of normal serum that I would feel inclined to give it a trial in future cases of purpura hæmorrhagica.

Many of the fortunately rare cases of acute hæmatemesis in infants are now regarded as belonging to the category of purpura hæmorrhagica. Whether anyone has used the polyvalent antistreptococcic serum in such cases I am not aware, but the remedy would seem well worthy of a trial in a complaint where recovery so seldom occurs.

#### **OUT-PATIENT'S ROOM**

CREAT NORTHERN HOSPITAL.

F'at Foo!

BY ARTHUR EDMUNDS, M.S., F.R.C.S.

AMONGST the out-patients was a girl, æt. 16, who came up with her foot in plaster of Paris. She had presented herself at the out-patient department several weeks previously complaining of severe pains in the left foot. She was a tall, overgrown weakly girl, and it was obvious that before it would be worth while attempting any serious treatment of the flat foot her general health would require careful attention. Accordingly arrangements were made for her admission to a convalescent home for a few weeks, and she returned from the institution considerably stronger, and in better health in every way.

Flat foot, Mr. Edmunds said, is primarily in this type of case due to a muscular weakness, and it must be remembered that however efficient the treatment for restoration of the arch, the support of this structure ultimately depends on muscular tone, and for this reason the patient's general health is of prime importance. The condition present in this girl was more however than a mere muscular defect as it was impossible to restore the arch by posture or by simple manipulations. The head of the astragalus formed a conspicuous projection on the inner side of the foot, but there was no evidence of any deformity of this bone. The patient had been admitted to hospital, and under chloroform the contracted ligaments on the outer side of the foot had been torn across, and the foot forced into a natural position, the prominence caused by the astragalus completely disappearing. The foot was then put up in a firm plaster of Paris casing which was left on for three weeks. At the end of this time the patient once more presented herself at the out-patient department, and the plaster was carefully removed in such a way as to allow the posterior and lateral portions to used as a splint until a proper apparatus could be constructed. This Mr. Edmunds pointed out is best made on the lines laid down by Whitman, that is to say a cast is taken of the foot as it lies upon its outer side with the arch restored as much as possible. method adopted in this case is, he thought, perhaps the simplest: the foot is well greased or oiled and arranged upon a chair similar to the one on which the patient is seated, lying upon its cuter side, the knee being flexed nearly to a right angle. A thick plaster cream is then mixed, and a sheet of lint about a foot square thoroughly impregnated with it; the foot is laid upon the sheet with the outer border parallel to and about three inches from one of its sides. The lint is then folded up over the sole of the foot and brought up on the inner side to a point just at the level of the internal malleolus; al! projecting corners are folded backwards towards the sole, and the plaster allowed to set. When this has occurred the foot is allowed to set. When this has occurred the root is removed from the plaster casing, a matter of but little difficulty, especially if it be done before the plaster is quite hard. A few cracks may form, but it would be easy to make these close without distorting the mould. The mould is now lubricated, and some fresh plaster cream prepared come explanation. and some fresh plaster cream prepared; some ordinary tow is impregnated with this cream and laid in the mould so as to build up a thick hollow lining to it. When this fibrous plaster has set the mould can easily be removed by forcing open the two sides and a cast of the foot obtained when which the addiagram and of the foot obtained, upon which the ordinary markings by Whitman's brace can be made for the instrument maker. This method, he considered, is simpler and more accurate at any rate in any but the most skilled hands than the method of making a plaster cast in two halves, and the whole process can be finished with but very little mess in about twenty minutes. When this cast has been satisfactorily made the plaster casing is reapplied, and the patient sent home until the steel brace can be prepared.

#### OPERATING THEATRES.

ROYAL FREE HOSPITAL

APPENDICITIS WITH ABSCESS .- MR. WILLMOTT EVANS operated on a young woman, ret. 23, who had been complaining for about three weeks of an indefinite dull pain in the right iliac region. She had felt out of sorts, but had been able to do her ordinary work. On the day before admission the pain had become more acute, and she had had some fever. A doctor had then seen her, and had recommended her removal to the hespital. When admitted the abdominal wall in the right iliac fossa was found to be rather har though it moved slightly on respiration. Nothing definite could be felt on palpation, though she complained of a little tenderness. The bowels were acting regularly; her temperature was a little over 100°, and her general condition seemed very good.

It was decided to watch the patient; she was ordered milk diet. The next morning she remained in the same condition, and the day following also, but on the evening of the third day the temperature began to rise, and when the patient was seen by Mr. Evans at 10 o'clock the temperature was 102°, and a definite localised swelling could be felt in the right iliac fessa. He decided to operate at once. The patient was taken to the theatre and anæsthetised. An incision was made in the right iliac fossa directed to the right iliac fossa directed and inverted and inverted its length was about three downwards and inwards, its length was about three inches, and its upper extremity situated about three inches above, and internal to the anterior superior iliac spine. The incision was deepened until the subperitoneal tissue was reached; as far as possible the muscular fibres were separated rather than divided. Slight ædema of the subperitoneal tissue was noticed, and the peritoneum had a yellowish tinge. An incision was made through the peritoneum, and some four ounces of pus were evacuated. The cæcum presented in the wound, and by gentle rotation it was possible with very little disturbance of the parts to reach the base of the appendix. The appendix was ligatured close to its base, and was cut through. About an inch of it was removed as far as the place where it was completely disorganised. The meso-It would not have been appendix was ligatured. possible to discover and remove the remainder of the appendix without much more disturbance of the parts.

A drain was inserted into the abscess cavity which was found by a finger to pass inwards over the brim of the pelvis. The wound was dressed with cyanide gauze after a couple of stitches had been put in in the

upper end of the incision.

Mr. Evans said the time for operating on a case of appendicitis is still unsettled. When appendicectomy was first introduced the practice of many surgeons was to operate for the removal cf the appendix at the earliest possible moment, and this practice was even more prevalent in the United States of America than in this country. A few surgeons still maintain that it is wise to remove the appendix as soon as the diagnosis of appendicitis is made, but in this country at least they form a very small minority. Very soon it was recognised that the best time to operate on an appendix was not during an attack of appendicitis, but after that attack had subsided, and therefore it is the custom now with most surgeons to postpone operation in some cases while they operate early in others. In classifying these cases for therapeutic methods a sharp distinction must be drawn between those in which an abscess has formed and those in which no abscess has formed. To consider the latter class first, Mr. Evans said: If we were to leave these cases untreated we should find that in a large proportion of cases of appendicitis in which the symptoms are not very acute recovery will follow without any surgical treatment. In some of these no second attack of appendicitis will ever occur, while in others a second attack, third or even more will follow at irregular intervals. What then should be done? He thought it might be laid down as a rule that in cases where the general condition of the patient, the small degree of fever, the quietness of the pulse point small degree of lever, the quietness of the pulse point to a mild attack, it is well worth while to postpone any operative interference until the attack has subsided; then if indications for operation are present appendicectomy can be done. What are these indications? If after the first attack some palpable swelling is left behind or marked tenderness, then he considered it advisable that operation should performed without waiting for a second attack. Still more if the appendicitis just past is not the first, but the second, third, or later attack, the indication for operation is still more imperative. If on the other hand the attack is the first from which the patient has suffered, and physical examination after its subsidence gives no evidence of any abnormal condition, no thickening, no swelling, then he thinks the surgeon is justified in suggesting that the operation should be postponed for a time to see what may happen; and it will be found that in a large proportion of these cases, probably over 60 per cent., no further attack of appendicitis will ever occur. The operation of

appendicectomy in the interval between two attacks (the interval operation as it is called) is accompanied by an exceedingly low mortality, in fact in competent hands it has no mortality at all. There are, however, some cases in which though no abscess has formed, the attack is of an exceedingly great virulence: the microbic involvement of the appendix has resulted in widespread death of the appendical wall, and the sloughing wall will give way, and the contents will pour out into the general peritoneal cavity before any protective adhesions have had time to form. The only hope of saving these cases is by immediate removal of the appendix. How then can these full protecting cases he recognised. these fulminating cases be recognised? Some say that it is impossible to recognise them, but Mr. Evans thought this view was too pessimistic; many points have to be considered, and too much reliance must not be placed on any single point. First as to the temperature. Severe cases are usually characterised by a high temperature, though it must be remembered that sometimes the temperature is normal or even subnormal. The pain is also usually more acute, and the rigid motionless abdomen points in the same direction. On the whole the most trustworthy criterion is to be found in the pulse, the rapidity of which is usually out of all proportion to the temperature. He would also lay great stress on the general aspect of the patient: it was impossible to describe in words, he said, what that aspect is, he could only say that the patient looks more ill than his symptoms and signs would suggest he was.

Secondly, he spoke of those cases in which an abscess has formed: in these it is well to evacuate the pus as soon as proof of its presence has been obtained, but as a rule it is not advisable to insist on removing the appendix at the same operation unless the lie of the parts renders it possible without risking the hreaking down of protective addesions.

ing the breaking down of protective adhesions.

Lastly, he pointed out there are certain cases in which an abscess has formed, and has burst into the general peritoneal cavity before the surgeon has seen the case. He would only say at present that the best treatment was to drain the abdominal cavity as thoroughly as possible, the result depending, in his opinion, rather on the nature of the microbial infection than on the special method employed for cleansing the peritoneum.

The abscess cavity in the present case slowly filled up, and eventually healed, though there was some weakness of the abdominal wall at the site of the scar.

#### TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, MARCH 26TH, 1909.

The President, Dr. W. G. SMITH, in the Chair.

GAS IN THE STOMACH: ITS CAUSATION AND TREATMENT. DR. CAHILL defined the terms "fermentation" and "putrefaction"—the former being mainly applicable to the decomposition of "carbohydrates," the latter to the decomposition of "proteids" and "fats." The end-products of each process was discussed. The causal factors in the production of gastric gas were considered under the following heads:—(1) Air swallowing. (2) Chemic gastric respiration. (3) Mechanic gastric respiration. (4) Inorganic production of CO<sub>2</sub>. (5) Organic production of CO<sub>2</sub> and associated gases. (6) Spasm of cardia or pressure from without. The treatment of the various causes—including "lavage" diet, rectal feeding, drugs—was referred to, and a plea was made for the more careful investigation of the causes of "flatulency."

The PRESIDENT took exception to the distinction drawn between fermentation and putrefaction. He looked on putrefaction as a mere accident of decomposition; it was simply fermentation plus smell. He thought the terms were not susceptible of accurate

definition in the sense in which Dr. Cahill used them. He was not hopeful of the possibilities of intestinal antiseptic treatment, as none of the things used had

come up to expectation.

Dr. Cox said it was a rare thing for an amount of air capable of causing trouble to get into the stomach by swallowing. He thought the troubles must be looked for within. They had seen cases where mental trouble or sudden shock had led to gas being formed by a process which was probably neither fermentation nor putrefaction, and in which a great amount of misery and depression was relieved by the expulsion of gas. In such cases he thought the subjective sensations were as much to be accounted for by the depression associated with mental causes as by poisoning of the blood by the by-products of digestion, or the un-

eliminated products of liver digestion.
Sir John W. Moore said that people with bad teeth, who could not masticate their food, swallowed with it very considerable quantities of air. They were familiar also with the connection between cardiac and vascular lesions and gas in the stomach. It was exceedingly hard to disinfect either the stomach or intestines, but symptoms could often be relieved by attention to the toilet of the mouth.

attention to the toilet of the mouth.

Dr. Cahill, in reply, said the distinction drawn between "fermentation" and "putrefaction" is only for clinical use, seeing that the processes exhibit no absolute line of demarcation. Stress laid on air swallowing by Sir John W. Moore is in agreement with the observations of the writer. An illustrative case of inflammable gas (CH<sub>4</sub>) was quoted, a parallel to that noted by the President from the work of Sir Henry Marsh. Henry Marsh.

NOTES ON A CASE OF PORT WINE COLOURED URINE (H.EMATOPORPHYRINURIA).

CHLEMATOPORPHYRINURIA).

Dr. PARSONS said Miss A. B. came under his care early in June suffering from diffuse abdominal pain, vomiting, and constipation. The urine, on standing, became of a deep port wine colour (specimen exhibited). It contained neither albumin nor blood. Neither trime after ten days patient improved and Neither trional nor sulphonal had been administered at this time. After ten days patient improved, and went away for a change. The symptoms, however, recurred, and she was admitted to hospital towards the end of June. Abdominal pain was present. Sleeplessness was pronounced, and she was given on four consecutive nights 15 gr. of trional. The urine was of a similar colour to that passed early in her illness. Towards the end of the first week after admittance she complained of severe pain in her feet, and on July 7th complained of severe pain in her feet, and on July 7th her arms were almost powerless, and she was so ill and feeble that she could barely move in bed. On July teeble that she could barely move in bed. On July noth the rectal sphincter was relaxed and she commenced to pass under her. A few days later swallowing became difficult, and death took place in a little over two weeks after her admission to hospital, and in less than seven weeks from the onset of her symptoms. Specimens of the urine passed shortly after her admission to hospital, and a day or two before her death, were exhibited. They were of a rich port wine colour, and, though nearly three years old, were acid in reaction and showed no evidence of decomposition. Though hæmatoporphyrin was probably present, the red colour was not due to this substance, and it was considered that the term hæmatoporphyrinuria, applied to urine of this class, was misleading.

The paper was discussed by the President and Dr. Eustace.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, April 11th, 1909.
At the Medical Society, Hr. Ernst Rosenberg spoke

DIAGNOSIS AND TREATMENT OF DEEP-SEATED DISEASES OF THE COLON.

In describing the means of diagnosis, he first mentioned digital examination, examination of the fæces,

and recto-romanoscopy. It did not matter with what instrument the latter was carried out. Any of those described answered the purpose very well. It was rather a question of which the user was the most accustomed to. It was not necessary to inflate with air. The parts should be thoroughly cleaned, after which the knee-elbow position could be made use of. He gave a note of warning against the use of the sound. He described acute and chronic inflammations of the large intestine, and the usual treatment. He dwelt on the treatment of the chronic form of inflammation of the colon, and recommended flushing of the parts with astringents, after first washing out with soda solution. When the end was not attained by this means, he made local applications in the form of powder (magn. ust. tannin, and zinc. sozoiodolicum), by means of the recto-romanoscope. The aim was attained by this method only when the extreme upper The aim was Amongst the diseased surface could be reached. Amongst the diseases of the large intestine a special place was taken by strictures, for the treatment of which he made use of dilators which he had had constructed after the manner of Kollmann's urethral dilator.

At the Verein für Innere Medizin, Paul Mayer contributed a note on

#### BOUMA'S DIABETES MILK.

This milk contained only the smallest quantity of milk sugar (about o.1 per cent.); it was rich in fat, well tasted, and it could be sterilised. He had procured it in a sterilised condition from Vienna, and had used it with success in a number of cases of diabetes, the success being specially pronounced in the cases marked by emaciation. The milk could be obtained in Berlin in a fresh state, price about 6d. the half-litre.

Hr. Langstein showed an eight months' child that for the last four weeks had suffered from intestinal catarrh, with great thirst. On examining the urine it was found to contain 3.5 per cent. of sugar. This proportion was greater than had ever been recorded in the case of so young a child, with the exception of one reported by Rossbach, coming on after injury to the head. He had prepared a sugar-free milk, and after the use of this the sugar entirely disappeared from the urine; a marked acidosis, however, still remained. It was ascertained that the mother had given the infant large quantities of sugar every day for the last six months (200 grm. a day).

Hr. F. Blumenthal was in entire agreement with Mayer's favourable opinion of Bouma's milk. Its decomposition differed from that of other milk. As it contained no sugar it did not turn sour, but decomposed; but the products of decomposition did not make their presence known by emission of sulphuretted hydrogen until after the fourth day.

#### A CASE OF FÆCAL TUMOUR.

Hr. Lazarus related the case of a young man, æt. 35, who had suffered for five years from tuberculosis and diarrhæa, with abdominal pains, so that the bowel affection was looked upon by the medical man in attendance as tuberculous. There was persistent diarrhæa, which could only be kept in check by large doses of opium. When the speaker first saw the patient he was in a very much reduced condition; on examination a large, nobbly, easily movable tumour examination a large, nobbly, easily movable tumour was felt in the region of the colon, the nature of which he could not at the time determine. It might be the rolled up omentum, but the ease with which it could be pushed downwards was against this view. It might be a packet of enlarged glands, but against this was the fact that the tumour changed its position every day, and was observed to be smaller after defæcation. The patient got no more opium, his stools became formed, and he ate with a good appetite. But he died. The preparation shown was the colon filled along its whole extent with a stony, hard, black fæcal mass; no way out could be found for it.

Hr. Rothmann, senr., had seen two cases of fæcal tumour, there was high fever in one of the cases. After infusions from a height the tumour diminished in size and at last disappeared; finally a blackish, stony hard piece came away. The second case was stony hard piece came away.

similar to the first, was treated and ended in a similar manner

Hr. Kraus remarked that in patients treated with tannin such tumours sometimes formed, but Hr. Lazarus said he had discovered no mention of tannin in the prescriptions which he had looked through.

# AUSTRIA. Vienna, April 11th, 1909.

BARLOW'S DISEASE.

KNOPTELMACHER presented a case to the Gesellschaft der Aerzte, aged 9 months, with the typical symptoms of Barlow's disease, viz., pale and anæmic, restless, and great swelling over the left tibia, particularly the and great swelling over the left tibia, particularly the lower third of the bone, where the tenderness and pain were severe. The left ulna was swollen, but the changes were greatest in the middle portion of the bone. There was hæmorrhage into the skin in both upper and lower eyelids, as well as the mucous membrane of the lips and cheeks, while the gums were quite normal. The most striking symptom was the exophthalmus, the left being greater than the right, which led to the presumption of retro-bulbar subperiosteal hæmorrhage in the orbit. been fed with mother's milk at first, but latterly with cow's milk mixed and reduced with water.

POLIO-MYELITIS ACUTA ANTERIOR.

Semeleder showed a female, æt. 14, who was attacked with paralysis in her second year of life in both lower extremities, the right being complete, while the left retained the power of extension and adduction in a small degree. After the lapse of twelve years a faint contraction can be observed, but the contraction of

nothing but orthopædic aid could be offered, but every home and foreign instrument failed to give any relief. Having the shoulders well developed. leder has devised an apparatus by which the force of these muscles can be utilised for hips and legs. With this apparatus the patient can rise and walk about

with comparative ease.

with comparative ease.

TETANY PARA-THYREOPRIVA.

Eiselsberg exhibited a case of tetany, æt. 33, on whom he had operated for goitre in 1905, which had caused a good deal of constriction in the air passage by the stenosis in the trachea. A few days after the operation tonic cramps in the hands and feet commenced, while Chvostek and Trousseau symptoms were well marked. The use of thyroid tablets only gave temporary relief, which were persevered in till the following year, when it was deemed advisable to transplant a few epithelial bodies into the sheath of the rectus muscle, but in spite of this, though feeding with raw sheep's gland and taking the tablets regularly, the cramps persisted. In June, 1908, she became larly, the cramps persisted. In June, 1908, she became pregnant, when the fits relaxed, but a month ago they commenced with more severity than ever in the upper and lower limbs, with great difficulty of breathing at night. The right vocal cord is paretic, and the voice is hoarse. The left ulnar is active under the galvanic current, but not unduly excited. In conclusion, he criticised the removal of the epithelial bodies, and thought they were too important to be neglected. He had no doubt the extirpation of these bodies with the gland was the cause of the tetany, which may be alleviated by transplantation, etc., but seemed to fail

UNILATERAL TABES.

Flesch recorded a peculiar case of tabes affecting one side of the cord, though the symptoms were often bilateral. The tendon reflex of the Achilles was not affected on the right side, though quite lost on the

Wirth asked if lumbar puncture and Wassermann's test, when applied, or the globulin reaction of Nonneapelt, would be of use in these cases; but Flesch could see no useful end these would serve.

Algyogyi said he had observed lightning pains in the lower intercostal spaces of one side in tabes, cases which may be of the same nature as Flesch's results.

PRECIPITATION IN TUBERCULAR SERUM.

Stork recounted the result of 800 cases on whom he had experimented with a 1 per cent. solution of

carbolic acid in a physiological solution of common salt. When this is added to the sera of phthisical patients, and the mixture placed in the incubator for 12 hours, a precipitate is formed, while a "bacillen-lipoid" is found floating on the surface, which seems to come from the bacilli in the fermentation. When emulsified, a ½-gram of lipoid material may be obtained from a ½ of a litre of the saturated solution. He found this in 75 per cent. of his cases, all of whom were suffering from pulmonary tuberculosis. Unhappily the reaction is not confined to this class of cases, Unhapas he found it present in tumours and diabetes when well advanced. It was also met with in the first stage well advanced. It was also met with in the first stage of infectious diseases, or after a rich milk diet. It is worthy of note that the morning serum is devoid of this reaction. Other bodies, like lecithin, glycocholate of soda, and even vaseline, require to be guarded against in this reaction.

#### HUNGARY. Budapest, April 11th, 1909.

SHORTSIGHTEDNESS 14 CHILDREN.

In concluding his very instructive article on the examination of 200 school text-books from a sanitary point of view, Dr. Fejér draws particular attention to the fact, as substantiated by many prominent investi-gators, that shortsightedness in children either originates or develops in school. The chief causative agency, therefore, is to be found in too prolonged reading, writing and drawing, whereby accommoda-tion as well as convergence are greatly fatigued. Undue strain of the muscles of accommodation causes an active hyperæmia, the return flow of the venous circulation is greatly hindered, there is an increase of the intraocular pressure, and the sclerotic is gradually stretched. Too strong convergence works even greater harm for the eye in various ways. It must also be observed that in some of the children shortsightedness is hereditary and they become affected so much sooner than their healthy comrades. In addition to the above cause producing shortsightedness, mention must be made of poor, or insufficient lights with which many school buildings are supplied; the same may be said of unhygienic school furniture. As regards the influence of books on eyesight, the author insists that paper should not be polished, for under artificial light a polish on a paper prevents the eye from seeing well, and necessitates moving the book to and fro, as well as frequent changes in the position of the head. Again, the paper should be thick enough to prevent the printing of the next page from intruding itself upon the reader's eye. Although a few authors recommend yellow paper, the majority speak in favour of white, for the contrast between the print and the paper is so much more striking the whiter the paper. PREVENTION OF IODISM.

Dr. Leser believes (Orvosok Lapja, 1909, No. 13) that iodised alkalies suddenly flooding the organism, and pouring out through the mucous membranes, cause catarrhal conditions on these, and thus lead to iodine intoxication. He suggests, as a prophylactic measure, that the iodine salts be administered in a mucilaginous vehicle in order to render absorption slower and gradual. In some cases it may be advisable to give the iodine per rectum, where absorption is also slower. Another prophylactic measure is to use the iodine in the form of iodised fats, or the injection of iodipin. In cases of pronounced idiosyncrasy, the latter may be used at first in small injections in order to accustom the organism gradually, and then the internal administration may be gradually substituted.

ANTI-STREPTOCOCCUS SERUM IN ARTICULAR

RHEUMATISM.

The employment of sera in this disease has been made the subject of careful study by Dr. Weiss, of Pistyan (Hungary), who claims that the lymphatic ring in the pharynx affords the point of entrance for the cocci, as also stated by Menzer, of Germany. Weiss produced his serum from streptococci derived from the original, associated with articular rheumatism. As the serum is not passed through animals, however, exact dosage is not possible, he has lately made a new test of this agent in 15 cases, most of which were characterised by an early passage from the acute into the chronic stage, and in which other remedies had met with little or no success. From one to eight injections were given in each case, the dose varying from 5 to 20 cc.m. The quantity was rapidly increased until a distinct reaction was obtained, the next injection being then delayed until the effects of the other had fully subsided. The reaction varied greatly in different patients. In some there was high fever and marked local changes, in others only the latter appeared, and in a few no change at all took place. Local reactions were observed only in the joints, where the injection had been made, the others remained free. In summarising his results, Dr. Weiss states that definite benefits were seen in six cases, a certain degree of improvement in four, and no effect at all in five. The good effects consisted in an abatement of the pain and increased mobility. He does not believe that this serum exerts a specific action similar to that produced by diphtheria serum or tuberculin. He admits, however, that undoubted results have been obtained, especially in the subacute cases. In acute cases very little effect was observed, and in chronic cases none at all. It does not seem advisable to employ the serum until all other methods have failed, and a better standardising is at present a great desideratum.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME,

#### SCOTLAND.

Mr. Sydney Holland's Allegations Craiglockhart Poor-house.—The Parish Council have communicated to the Press a report dealing with Mr. Holland's attack on the management of the poor-A direct denial of the accuracy of some of Mr. Holland's statements is given—operations are not performed by the lady house surgeon; the consulting medical officer attends at least thrice a week, not twice, as stated; there is no ophthalmic ward; records of all cases are preserved. Other parts of Mr. Holland's charge are described as misleading—(1) The duties of the resident are laid down by the Local Government Board, and a great deal of medical work, e.g., ordering diets, is of a routine nature. (2) There are 9 day nurses and 6 night nurses for the 13 wards; so that to say "many" of the wards have no trained nurses is an exaggeration. (3) The conditions under which operations take place may be likened to what exist in a private house; there is no great amount of surgery done, and to compare the theatre with standards of the same training of the same training and to compare the theatre with standards of the same training of the done, and to compare the theatre with standards of a general hospital is unfair. (4) Not more than half-adozen post-mortems are performed annually. Expert surgical help is available for special cases. Three-fourths of the 280 cases require no active medical or surgical treatment, they are chronic senile, nervous and rheumatic cases, needing little except nursing. The Chairman of the Parish Council points out that while he sympathises with the disappointment one accustomed to the relation that while he sympathies with the disappointment one accustomed to the palatial theatres of London hospitals would feel on viewing the simple, though thoroughly hygienic, arrangements in Scottish poorhouses, the Council can only administer the law as it stands, and they are fully aware of its many shortcomings.

MEDICAL INSPECTION OF SCHOOL CHILDREN.—In a memorandum issued by the Scottish Education Department for the guidance of School Boards, the principle is definitely laid down that for each area a single responsible medical inspector is required. Neither he nor his assistants should be allowed to engage in private practice. In rural parishes it may be possible, however, to utilise the services of local practitioners as assistants, and in some districts the employment of nurses may be indispensible. Great difficulties are anticipated in carrying out the work in certain districts of the Highlands where the population is much scattered. The memorandum is especially emphatic in protesting against any arrangement being come to which will allow of one practitioner being called upon to examine another practitioner's patients.

Notification of Births in Glasgow.—During 1908, 86.3 per cent. of the births were notified, the ratio of notifications to births was highest (99.3 per cent.) in Cowcaddens Ward, one of the poorest districts. In the better quarters of the town it was lower. Of the 20,000 odd births notified, 45 per cent. were attended by medical men, 55 per cent. by midwives. The incidence of puerperal fever was considerably higher in the latter group than in the former; 117 cases were notified, of which 32 had been attended by medical men (3.4 per 1,000), and 85 by midwives (7.5 per 1,000).

#### LETTERS TO THE EDITOR.

[We do not hold curselves responsible for the opinions expressed by our Correspondents.]

#### ALCOHOLIC SHAM TONICS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Some weeks ago you allowed me to call attention to the traffic in sham tonics containing alcohol. I pointed out that vast sums were being spent on advertising these pernicious compounds, a measure of the extent of their sales; that a craving for alcohol was being created in great numbers of innocent people; and that secret drinkers among women were being provided with the means to indulge their vice without some of the restraining shame hitherto existing. Since I wrote, a series of authoritative analyses of these "tonics" has been published, and in every instance it has been proved that they contain as much alcohol as is found in ordinary port wine. Thus the wretched dupes who put their trust in these compounds are often taking the equivalent of from three to six glasses of port a day. No doubt the worst of these concoctions contain no wine whatever. It would take a clever palate to distinguish what is the alcoholic constituent of a mixture of so-called 'beef tea" with various "flavouring" ingredients, and it is not likely that the unscrupulous vendors of such mixtures would use good wine when "silent" spirit would answer the same purpose. I ask again, Sir, whether the temperance organisations would not be well employed in forcing this question on the attention of Government? The Times a few weeks ago had a leader on the "Care of the Inebriate," exposing the evils of the traffic, and advocating the prohibition of the sale of alcoholic medicines by law. This exposure has not, however, stopped the appearance of enormous and costly puffs of these preparations in all the leading newspapers.

I am, Sir, yours truly,

MEDICAL TEMPERANCE REFORMER.
London, S.W., April 10th, 1909.

#### THE DECLINING BIRTH RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Through a curious coincidence since offering my few simple remarks on this subject it has come to pass (so the Daily Mail informs us) that the birth rate has risen "The first increase in fourteen years." Moreover I read recently an increase has also taken place in France. I refer to this as a fulfilment of one of my predictions, viz., that amongst the homo species the supply would always be equal to the demand. Perhaps not apparent, but nevertheless real. Let us hope that this increase may not prove the old adage that "The last feather breaks the camel's back."

The facts your correspondent, "Student of Sociology," calls attention to are matters of common knowledge, which no careful observer or constant reader of the daily papers would be likely to overlook. If a diminishing birth-rate on the face of a surplus population, alien emigration, unemployment, intense competition, and widespread destitution is farcically called "Racial suicide," I venture to think an increasing birth-rate under these conditions might with equal propriety and with more reason be styled racial homicide.

Your correspondent's remarks about India are surely ill-timed or inopportune. It should, I think, be

evident that this portion of our Empire is above all others the most fragile and insecure. Religious animosities, the spread of education, the admission of natives in the Supreme Councils of State are perilous in the extreme. No living being can forecast security of tenure in these regions. In the Brighton Herald (November 14th, 1908) there appeared a report of a speech by Mr. Kennedy on the "Curse of Empire," in which he stated: "From January 1st, 1889, to September 30th, 1901, two British subjects in India died from starvation every minute of every day and every night." Assuming this statement to be approximately correct, would your correspondent, I ask, advance this as an argument in favour of an increasing birth-rate and Empire building? But for your valuable space I could add a good deal more,

In conclusion will your correspondent bear in mind that our insular position as a nation, plus the navy, no longer, nor can it in the future, afford us the security as heretofore. The issues of the fight in future warfare are no longer confined to terra firma nor the surface of the water. For what with undercurrent explosives and aerial navigation, which may spill its spoil at any moment, and on any spot, with ghastly destruction so much so that war may almost be described in the future as being waged in the seven heavens and the bottomless pit. The only card (as appears to me) left our country to play is in the spread of agriculture. Landowners will probably realise ere long that title deeds no longer afford the security to their estates as of yore, especially when we discover international treaties are openly defied and brought to nought. Hence landowners may be induced to surrender land, the only possible means of rearing an increasing and healthy population to protect our shores, and which we sorely need, and which we cannot afford under existing circumstances to send abroad.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, April 8th, 1909.

NATIONAL SERVICE AND THE MEDICAL PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-Your issue of March 24th contains a letter from "Criticus," in which an endeavour is made to discredit the system of National Service, on the grounds that it would lead to an increase in venereal disease, and the writer goes so far as to say that, "In Germany it is recognised that military service increases the amount of venereal disease." I trust that you will let your readers have an opportunity of knowing the real truth on this point, vouched for by statistics given on the highest authority. On page 15 of the Report of the Army Medical Department for the year 1906, Table No. 7 shows that in the German Army the admissions to hospital for venereal disease were in the ratio of 19.8 per thousand, or rather less than 2 men out of every 100. This fact entirely refutes the statement in the same letter that "the garrison towns of Germany are known to be the hotbeds of the most virulent forms of venereal disease," but in order to give full effect to the relatively minute ratio of the disease mentioned among German soldiers, I will quote the figures for the voluntary armies of England and the United States respectively from the same table. They are:—
"United Kingdom, 81.8 per thousand; United States, 178.72 per thousand."

I am, Sir, yours truly,
GEORGE T. SHEE, Secretary.
National Service League, 72, Victoria Street,
Westminster, S.W., April 5th, 1909.
P.S.—The figures for 1907 are:—Germany, 18.8;
England, 71.9; United States, 158.91.

#### **OBITUARY.**

SURGEON-COLONEL BACKHOUSE, F.R.C.S.

We regret to record the death of a well-known citizen of Dublin-Surgeon Lieutenant-Colonel

Backhouse, late of the Indian Medical Service, after a short illness. Colonel Backhouse, who was a student of the Royal College of Surgeons of Ireland, received his medical training at that school and at the Meath Hospital and Mercer's Hospital. He was qualified in 1868, and took the Fellowship of his College in 1882. His father was an Army Surgeon, and was attached to the 3rd Dragoons, and so it was only natural that the son too should seek to enter the military branch of his profession. Accordingly, shortly after he was qualified he entered the Indian Medical Service, in which he spent the greater part of his professional life. In India he won a distinguished position, and on several occasions his work was brought prominently to the notice of the Government of that country. He retired with the rank of Lieutenant-Colonel in 1897, and since that time he devoted himself to the task of assisting the work of the medical charities in Dublin. He took a very active part in the work of the Dublin Hospital Sunday Fund, and as a member of its visiting committee he was a well-known figure at the different hospitals. He was also a strong supporter of the Royal Medical Benevolent Fund of Ireland, and of the National Children's Hospital in Harcourt Street. By all these institutions and charities his loss will be deeply felt.

DR. THOS. CRAWFORD HAYES.

THE death of this gentleman occurred at his residence in Clarges Street, Mayfair, London, last week. Dr. Hayes was a gold medallist of Trinity College, Dublin, and graduated M.D.Dub. in 1875. He soon after proceeded to London, and was made a Fellow of the Royal College of Physicians in 1889. He was also an Hon. Fellow of King's College, and took up gynæcology as his speciality. At the time of his decease he was Emeritus Professor of Medicine of King's College, and a Consulting Physician to the King's College and Royal Free Hospitals. He also held appointments at the Evelina Hospital for Sick Children and the General Lying-in Hospital.

#### REVIEWS OF BOOKS.

THREE BOOKS ON CANCER. (a) THREE works on cancer lie before us, and it is interesting to compare them on their merits. first is a series of lectures on the pathology of cancer by Dr. C. P. White, which are full of scholarly information and illustrated with a number of excellent black-and-white plates. Dr. White uses the word "cancer" as covering all malignant growths, and we think, considering the modern trend of opinion, that he is justified in doing so. In the first part, on tumours in general the author essays a classification, which, if bold, is certainly very well done. Part II. deals with malignant growths generally, especially their characteristics, and modes of extension. Both these parts are brief and business-like. "Causation" is the subject of the third part, and we confess to finding it a little disappointing. We wish for a close study of the subject, and we get chiefly a résumé of opinions. The final section deals with the "Bearings of Pathology on Treatment," in which ancient and modern methods are discussed and criticised. Finally, there is an appendix, occupying nearly half the book, and consistent of illustrations. sisting chiefly of illustrations. As a sound abstract of modern views, these lectures are worthy of perusal.

Mr. Gibson's book is a conscientious study by a scientific man, approaching his subject from the statistical and biological points of view, and presenting a large number of interesting facts. It is certainly worthy of careful attention by those interested in the subject, and we shall await with interest the larger work, of which the present volume is only the fore-

<sup>(</sup>a) 1—"Lectures on the Pathology of Cancer." By C. P. White: M.A., M.D., F.R.C.S., Pilkington Cancer Research Fellow. London Shirratt and Hughes. 3s. 6d. net. 2.—"The Etiology and Nature of Cancerous and other Growths." By W. T. Gibson, A.R.C.S. London: John Bale, Sons, and Danielsson. 1909. 3.—"A Taeory regarding the Origin of Cancer." By C. E. Green. Edinburgh and London: William Green and Sons.

runner. We hope that the author will therein define more exactly the sources of the evidence he relies on. What we suffer from chiefly in regard to cancer is too wild, hypothetical, and half-true statements; and what we lack is definite information. For instance, all are agreed that cancer follows trauma in a certain number of cases. But how frequently there is such a relationship; what tumours most frequently occur, and in what sites, are merely matters of conjecture. Patients when they find a tumour think "they must have had a blow," and down in the hospital records goes, "History of Injury." Such evidence is worse than useless: it is misleading. We hope in this and similar matters Mr. Gibson will help us to more exact

The third book we have to deal with is also by a layman, but he, too, is of a scientific turn of mind, and his brochure is very suggestive. He approaches his subject from the botanical and industrial side, and cuts forward an assumption that cancer is due to a fungoid parasite and to the presence of sulphuric or sulphurous acid. Like many ingenious theories of cancer, it is *primá facie* plausible, but the author does not bring his charge home. Let him demonstrate his case, and we will be charmed to listen to what he has

to say.

#### SMALL-POX. (a)

Dr. RICKETTS states in his preface that for more than ten years he has been revolving the idea of writing a book on the diagnosis of small-pox, and we may truly say that his deliberation has amply justified itself, for the result he presents is unique. In the first place, the strict purpose of the book is to establish Dr. Rickett's theory as to the value in diagnosis of the distribution of the rash, and that he has done-satisfactorily. In the second place this book is unique in the value of the illustrations, which are so good that it is difficult to speak soberly about them. Both Mr. it is difficult to speak soberly about them. Byles's black-and-white photographs and the colour-photographs are as clear and realistic as anything we have seen, and the author is much to be congratulated on having secured an illustrator of such skill. For, as he himself says, without the illustrations to bear out his assertions, the demonstration of his theory would be almost impossible. As it is, it may be asserted that Dr. Ricketts has proved his point asserted that Dr. Ricketts has proved his point—namely, that the determining factor in the diagnosis of small-pox is the distribution of the rash, and thereby he takes us a long step forward in the solution of one of the most difficult of public health problems. Admittedly, the difficulty of nipping an outbreak of small-pox in the bud is the danger of mild cases being unrecognised, and yet to a practitioner at all acquainted with the characteristics of small-pox lesions, who knows how to appraise the value of the sites on which they appear, the problem of definite diagnosis is enormously simplified. We cannot here follow the argument for centrifugal distribution in detail, but it is carefully set out, step by step, in the book before us, and each step is abundantly illustrated, so that anyone who studies it carefully can hardly rise from the perusal without the conviction that his knowledge has been extended, clarified, and systematised, and his efficiency as a custodian of the public health definitely increased. It is a pleasure in these days of book-making to read such an able, sincere, and valuable work as that which Dr. Ricketts and Mr. Byles have given us.

SOURED MILK IN THE TREATMENT OF DISEASE. (b)

This little book of 32 pages is an amplification of a paper by the same author, which appeared in the Lancet of August 8th, 1908. In it he claims to set

London: Henry Glaisher.

forth, just so much of our present knowledge of lactic acid ferments as may be likely to be of assistance to the practitioner of medicine, in prescribing them in a scientific manner. It is divided into three chapters. The first chapter gives a brief account of autointoxication generally, and a more detailed account of intestinal putrefaction and the form of auto-intoxication which is produced by it. The manner of its recognition, and tests by which its amount can be estimated are also dealt with. Chapter II, is of special importance and value, for in it the author states how we may select a suitable preparation of lactic acid bacilli, either for the curdling of milk or for the acclimatisation of the organism in the intestines, from the many spurious commercial preparations in the market. The exact directions for use are carefully and lucidly described. The last chapter contains a list of the abnormal conditions for which the administration of lactic acid ferments may be employed. Some of these are diseases in which their value has been demonstrated, but their administration for others stands on a more questionable basis. We think, for example, that the author's enthusiasm has led him beyond the present state of our knowledge, when he includes neuritis and polyneuritis, progressive muscular atrophy, acute ascending paralysis, and chronic ill-health without any obvious cause, among the indications for this line of treatment. We would recommend anyone who intends to use lactic acid ferments, to first read this little book, for we feel sure that by thus acquiring a method of scientific therapeusis, he will be saved from much disappointment due to faulty methods of administration or the employment of inert preparations.

#### THE SOLAR SYSTEM. (a)

THE study of the solar system is not part of the medical curriculum, and may therefore attract the attention of those who have had a surfeit of Esculapian lore. The author's object has been to present the principal astronomical phenomena in a non-technical way, free from the mathematical embellishments that frighten the general reader. Thus described, few subjects possess such an overwhelming interest as the study of the heavens, and the reader is led on to familiarise himself with the awe-inspiring phenomena which are constantly recurring in space. Such a study is a useful "alterative" to the petty cares and worries of daily life. The author has accomplished in English what Flammerion long since did in French in the direction of generalising a know-ledge of these celestial wonders. Everybody, in the abstract, would like to know how and why the oceans rush hither and thither under the influence of the tides, why winter is characterised by cold, and summer by heat, why the moon is so inconstant, and so on. When we at last understand the means employed to estimate the distance of the sun and stars, we cannot but feel proud of our human intellect, which, limited though be its scope, is yet capable of bridging over the abyss, and of determining beforehand the exact phases of planetary oscillations. We cordially recommend this "popular astronomy" to the notice of our readers with energy and leisure enough to devise of things outside medicine.

#### DISEASES OF THE EAR. (b)

THE author has written a short practical account of diseases of the ear, specially intended for those who have not had an opportunity of devoting much time to the subject. The work is liberally illustrated with photographs of instruments which it is highly improbable that the reader-presumably a student or general practitioner-will ever use or require to recognise. Anyhow, the frontal mirror, with its central aperture, is quite old-fashioned. Most specialists aperture, is quite old-fashioned. nowadays make use of the French model of electric

<sup>(</sup>a) "The Diagnosis of Small-Pox." By T. F. Ricketts, M.D., B.Sc., M.R.C.P., D.P.H., Medical Superintendent of the Small-Pox Hospitals and of the River Ambulance Service of the Metropolitan Asylums Board. Illustrated from photographs by J. B. Byles, M.B., B.C., F.B.C.S., D.P.H. Twelve coloured plates, 110 black and white plates, 14 charts. London: Cassell and Co., Ltd. 1908.

(b) "Soured Milk and Pure Cultures of Lactic Acid Bacilli in the Treatment of Disease." By Geo. Herschell, M.D.Lond Pp. 32.

<sup>(</sup>a) "The Solar System." By Charles Lamb Poor, Professor of Astronomy in Columbia University. (Illustrated.) London: John Murray. 1908.

Murray. 1908.

(b) "Diseases of the Ear." By Hunter Tod. M.A., M.D.Cantab..

F.R.C.B. Eng., Aural Surgeon to the London Hospital. and Lecturer in Aural Surgery at the London Hospital Medical College. Oxford: University Press. 1907.

reflector, with double eye apertures, and in any event it was hardly worth reproducing so familiar an object. In this connection the author would possibly have been well advised to "rub in" more thoroughly the ever-present risk of mastoid and cerebral complica-tions in middle-ear disease. They are mentioned, it is true, but not in a way that strikes the attention, and yet the general practitioner can make no more frightful blunder than to overlook symptoms pointing to mastoid or cerebral infection, since prompt intervention alone can save the situation.

MIND AND ITS DISORDERS. (a)

WITH all new text-books one naturally asks oneself, is the appearance of this work justified? There are books galore on the subject, and is a fresh one needed? In the case of Dr. Stoddart's "Mind and Its Disorders," we have no hesitation in saying "Yes" to both questions. Indeed, if we compare it with much of the stuff which fifteen or twenty years ago passed as authoritative writing on insanity, we cannot fail to be struck with the great gulf which has been bridged. But, even among current works, Dr. Stoddart's is destined, we believe, to take a high, if not a commanding place, because it is the product of clear, definite conception of the physiology and pathology of the mind, applied to clinical phenomena. We are aware that dangers lie in a too rigid application of logic to conditions so nebulous as many mental disorders, but to the student it is an inestimable boon to have a definite philosophy running throughout his reading and ward-work, and even when his philosophy becomes a little shaky, or definitely breaks down, the departure from the normal impresses him at least as much as consistency would have done. Without being a full and exhaustive book, the one in our hand contains all that is necessary for general practice or examinations, and if it is free from jaunty tales or spicy bon-mols, which we have come to regard as the stock-in-trade of works on "insanity," it is at least stock-in-trade of works on "insanity," it is at least full of good pathology and good sense. There are, naturally, points that call for criticism. For instance, while we agree with Dr. Stoddart that a great deal of hysteria following injury is put down as "traumatic neurasthenia," we do not agree with the suggestion that traumatic neurasthenia has no positive existence. It is a definite malady, typically seen after head injuries, and has its clinical features and its clinical course. It is not uncommon to find a patient who has had a severe blow on the head become precisely such a neurasthenic as Dr. Stoddart describes in Chapter XIII. But, taken as a whole, we warmly recommend this book to such as wish to acquire a clear, balanced view of the disorders of the mind.

#### APPLIED PHYSIOLOGY. (b)

It is very true, as the author observes, that students are very apt to store their knowledge of the various subjects in water-tight compartments, forgetting that physiology, for instance, is useful only in so far as it enables us to gain an insight into pathology—in other words they are taught the normal working of the, body by way of providing a standard whereby to gauge the abnormal.

Then, too, physiology gains immensely in interest when it passes from the abstract to the concrete, and the practical bearing of physiological data is explained and commented upon. In addition to this, the method throws much light on processes which would otherwise

of being practically applied is very small, and this admission raises the question whether it is desirable or necessary to burden the student's memory with endless theories and hypothetical explanations which are periodically abandoned every few years, their place being taken by others of equally ephemeral status. Such lucubrations have no practical scientific value,

respectfully urge on the examining boards the propriety of insisting only on a knowledge of applied physiology, leaving the rest to "pure physiologists." Were this made part of the curriculum, Dr. Hutchison's book would be exactly what students would require, and, even as matters stand, they would find its perusal of great assistance in grasping the main facts of physiology.

PHYSIOLOGY AND PATHOLOGY OF URINE. (a)

In his preface to the first edition, the author remarked:—"The foundations laid by pathological chemistry are ever changing; what is accepted to-day may to-morrow be merely 'as a tale that is told." That was four years ago, and the truth of the statement is well exemplified in the additions and revisions observed in the second edition. Additional subobserved in the second edition. Additional substances are dealt with, new methods of analysis are incorporated, and the difficult problems that present themselves in the interpretation of the presence of various abnormal products are honestly met. We should have welcomed a larger space than two pages devoted to micro-organisms. Dr. Dixon Mann's devoted to micro-organisms. Dr. Dixon Mann's thoroughness in his treatment of the subjects on which he writes is too well known to need mention, and this book is particularly worthy of him It is certainly a volume that should be read by every practitioner and student.

## MEDICAL NEWS IN BRIEF.

Congress on Alcoholism.
The delegates to the 12th International Congress on Alcoholism, which will be held at the Imperial Institute, London, on July 19th and following days, will be entertained at a reception by the Government. The committee of the Congress, of which the Dean of Hereford is Chairman, have received an intimation to this effect from the First Commissioner of Works. The reception will be held at the Imperial Institute on the evening of Monday, July 19th, and the arrangements will be made and the expenses defrayed by the Government. The letter also states that only non-

alcoholic drinks will be provided for the occasion.

The Foreign Office has invited the Governments of the following countries to send official representatives to the Congress:—The United States of America, France, Germany, Denmark, Norway, Sweden. Switzerland, Russia, Austria, Hungary, Roumania, Italy, Belgium, Holland, Uruguay, and Mexico. All these were represented at the last Congress held in Stockholm the Colonia of the Colonia Communication. holm two years ago. The Colonial Office has extended similar invitations to the Governments of all the selfgoverning Colonies. The Government of India is now being consulted by the India Office on the subject of appointing a representative for India. By permission of the Home Office, Dr. R. W. Branthwaite, the Inspector under the Inebriates Acts, will attend the Congress; so also will Lieutenant-Colonel McHardy, Chairman of the Prisons Commissioners for Scotland, and Sir George O'Farrell, Inspector of Lunatic Asylums in Ireland. The delegates will number nearly 2,000, of whom probably 500 will come from foreign countries and the Colonies. The Hon. President is the Duke of Connaught.

Liability for Medical Attendance.

The Isle of Wight County Court Judge on April 7th found that Mrs. Woodhall, of Roland Gardens, South Kensington, described as a lady of considerable means, was responsible for her sister's doctor's bill,

amounting to £37.

Whilst staying with friends at Yarmouth, Isle of Wight, in September last, the sister was thrown out of a motor-car and sustained a broken leg. A doctor

and they cumber the ground; in fact, we would (a) "Mind and its Disorders," By W. H. B. Stoddart, M.D., F.R.C.P., Assistant Physician to Bethlem Royal Hospital. With illustrations. London: H. K. Lewis. 1908. Price 12s. 6d, net. (b) "Applied Physiclogy," By Robert Hutchison, M.D., F.R.C.P., Physician to the London Hospital. London: Edwin Arnold,

<sup>(</sup>a) "Physiology and Pathology of the Urine, with the Methods for its Examination." By J. Dixon Mann, M.D., F.R.C.P., Physician to the Salford Royal Hospital. Pp. 324 and xiii., with 30 illustrations. Second Edition, revised and enlarged. London: Charles Griffin and Co., Ltd. 1908.

attended the young lady regularly, paying over fifty visits. From time to time defendant was consulted about the case. When the plaintiff sent in his bill the claim was repudiated.

On behalf of the plaintiff, it was argued that Mrs. Woodhall not only approved Röntgen-ray treatment when it was recommended by the plaintiff, but paid

for it.

Counsel for the defendant suggested that the host of the young lady should pay, but His Honour held that that was a very strong proposition. If hosts were to be held responsible under such circumstances it would do much to upset week-end visits, now so much in vegue.

His Herour gave judgment for the full amount claimed, with costs, holding that defendant had held herself out as responsible for the payment for her sister's medical atendance.

Feeble-minded Children,

AFTER consideration of the Report of the Royal AFTER consideration of the Report of the Royal Commission on the Feeble-Minded, the Special Schools Sub-Committee of the London County Council state that there are over 8,000 children of school age in London who may be affected by its recommendations:—Mentally defective, 6,559; epileptic, 316; mentally defective, and also blind, deaf, or physically defective, 250; imbecile, 663; under Metropolitan Asylums Board, 632. The Sub-Committee, who reported to the Education Committee of the Council on April 2th consider that a register of mentally defective April 7th, consider that a register of mentally defective children should be kept, and that observation homes should be established for doubtful cases.

Ebbw Vale Dispute.

A FURTHER complication has arisen in the Ebbw Vale Workmen's Doctor's Fund dispute. Recently the Victoria section of the payees refused to accept the result of the ballot which was taken to effect a settlement of the disagreement caused by the Cwm section dispute, and on April 3rd the Ebbw Vale section at a mass meeting took a similar attitude. A heated discussion took place upon the manner in which the last ballot had been taken, several of the speakers declaring that the issue had been so confused as to make it misleading and that the result was not binding on either party. Several resolutions and amendments were submitted to the meeting, the one ultimately carried being: "That another ballot, arranged by the workmen themselves, should be taken, and that the plain issue be for or against the re-instatement, and that the conditions be made binding upon all parties."

The Royal Colleges of Physicians and Surgeons have decided to add the University of St. Andrews to and Surgeons the list of institutions at which the curriculum of professional study required for the diplomas of the two Royal Colleges may be pursued, and whose graduates may be admitted to the final examination of the Examining Board in England on production of the required certificates of study. The Grammar School, Cheltenham, has also been added to the list of institutions recognised by the Board for instruction in chemistry and physics, and the Merchant Taylors' School, London, which is already recognised in these two subjects, has also been recognised in biology. On the recommendation of the examiners for the Conjoint Public Health diploma, the Royal Colleges have decided to revise the syllabus of the subjects required for both parts of the examination. The new syllabus will come into force on January 1st next.

Another X-Ray Martyr.

In the House of Commons on April 7th Mr. Hobhouse, Financial Secretary of the Treasury, speaking on behalf of the Prime Minister, informed Mr. Bowerman, the Labour member for Deptford, that a grant had been made from the Royal Bounty Fund to Mr. H. W. Cox, who recently sustained serious and permanent injuries in connection with X-ray research work.

Mr. Cox is a manufacturer of X-ray apparatus.

Mr. Cox is a manufacturer of X-ray apparatus. His experiments with the X-rays resulted in an attack of dermatitis, which necessitated the amputation of the larger portion of his right hand, and one of the fingers of his left hand.

After the operation on Mr. Cox, the King sent a gracious message of sympathy to Mis. Cox.

#### Sleeping Sickness.

It is reported that the spread of sleeping sickness in the German West African colony of Togo is assuming menacing proportions. The flies which carry the infection, Glossina palpalis and Glossina fusca, are being found even in the dry season at some distance from the bush, and in entirely dry districts. They have even been discovered less than a mile away from a road where hitherto it has been assumed that these insects were unable to live. In the district of Buemu sleeping sickness has become a danger for everybody, including Europeans.

#### Beard of Superintendence of Dublin Hospitals.

THE Dublin Gazette announces a new departure of the Lord Lieutenant of Ireland in appointing a practical nurse to a seat on the Board of Superintendence of Dublin Hospitals. A vacancy was caused by the resignation of the Right Honourable Thomas A. Dickson, and Miss A. M. MacDonnell, the lady appointed in his stead, has had a lengthy and notable experience in hospital work. A native of Kerry, Miss MacDonnell was trained in Sir Patrick Dun's Hospital, Dublin, and for 21 years she has been Lady Superintendent of the largest hospital in Dublin. During the late Boer War, Miss MacDonnell acted as matron in the Irish Hospital, South Africa, and received not only the medal for service, but the Royal Red Cross, from His Majesty, for special and distinguished services. The work of the Board is to pay periodic visits to the various hospitals in Dublin and to report upon their efficiency, and this is the first time a woman has been appointed to the Board of Superintendence.

#### Australia's Crusade against the Mosquito.

WE understand that Dr. Ham, Commissioner of Public Health at Brisbane, recently called together all the medical health officers of his department, in order to put before them evidence of the particular mischief wrought by the mosquito, and to urge them to action. The spread of filarial disease in Queensland is the new indictment against this pest. The filaria parasite is a small nematode worm, conveyed to the blood either by mosquito bite or by drinking water polluted by mosquitoes, and the conference was informed that 17 per cent. of the patients lately admitted to the Brisbane Hospital were found to have the parasite in their blood at first examination. Even the dreaded yellow fever was spoken of as a possibility, seeing that Brisbane possesses a little striped mosquito known to be a carrier of the disease. Dr. Ham believes it feasible to subdue the pest, if not to destroy it altogether, and towards this end he recommends, among other things the wire correction of materials and the stripes. other things, the wire-screening of water-receptacles and the draining of all stagnant pools.

#### Vital Statistics.

The deaths registered last week in the 80 great towns of the United Kingdom corresponded to an annual rate of 17.9 per 1,000 of their aggregate population, which is estimated at 18,457,600 persons in the middle of this year. In the preceding three weeks the rates had been 22.1, 22.1, and 19.8 Measured by last week's mortality, the highest annual death-rates per 1,000 living were:—From all causes, 25.9 in Dublin, 23.7 in 1 iverpool 22.8 in Preston, 24.4 in Oldham. 27.0 in Liverpool, 23.8 in Preston, 24.4 in Oldham, 27.0 in Wigan, 27.3 in Great Yarmouth, 28.1 in Warrington, and 30.7 in St. Helens; from measles, 3.1 in Reading and in Sheffield, 3.8 in Bootle, 3.9 in West Hartlepool, 4.6 in Wigan, 8.7 in Warrington, and 14.8 in St. Helens; from diphtheria, 1.1 in Huddersfield; from whooping-cough, 1.1 in St. Helens and in Swansea, 1.7 in Norwich, and 3.1 in Preston; and from diarrhosa, 2.9 in Wigan. One death from small-pox was registered in Bristol, but none in any other of the 80 towns. In London the total number of deaths from all causes fell from 24.0 per 1.000 of a fortnight Liverpool, 23.8 in Preston, 24.4 in Oldham, 27.0 in from all causes fell from 24.0 per 1,000 of a fortnight ago to 18.3 last week.

#### NOTICES TO CORRESPONDENTS. Ec.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

#### SUBSCRIPTIONS.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January lat and July lat respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12. Messrs. Dawson and Sons are our special agents for Canada. ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

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Gd. per line beyond.

Ex ÆQUALL—It is becoming a question of grave doubt whether, after all, researches into "mouse cancer" will eventually throw much light upon the cancer problem. There must be something very different from cancer as produced in the mouse and that which is seen in man, having regard to the fact that in the former the disease disappears spontaneously in as much as thirty per cent, of the infected mice.

THE BURNING QUESTION OF THE DAY!!

(Cremation contrasted with Burial.)

EXEMMATION.

Heat the furnace raging hot, better far consume than rot. Ashes clean and inoffensive, funeral much less expensive; And your relatives will save, money wasted on a grave. When it comes to be your turn, leave your orders for an urn. BURIAL.

Why boxed up, to decompose, and offensive to the nose? Poisoning air with gases vile, in "bad odour" all the while, Friends unhappy weep and grown

Over cage when bird has flown.

Over cage when bird has flown.

A. D.

JUVENIS.—Our correspondent should communicate with the Registrar of the General Medical Council, 299 Oxford Street, London, W.

MANDAMUS (Torquay).—The point raised is somewhat an intricate one. If our correspondent is a member of either of the Medical Protection Societies, he would do well to inquire whether the regulations thereof cover the matter. Failing this, he should consult his solicitor.

R. D. Y.—The climate of Buxton or Harrogate would probably meet the requirements of the case.

"Out, madame is ill, but se doctor half pronounce it something very trifting, very small," said the French maid to an inquiring friend.

"Oh I am so religient for I are recommended.

riend. "Oh, I am so relieved, for I was really anxious about her," replied the friend. "What does the doctor say the trouble is?" "Let me recall. It was something very leetle," answered the French maid. "Oh, I hav it now! Ze doctor says zat madame has zo small-pox."—Philadelphia Ledger.

Spr.s.—The proposed articles would not be suitable for our

columns. columns.

ENQUIRER (Salford).—The population of the three large cities in India to which you refer is, according to the latest official statistics, Calcutta 1,014,438, Bombay 982,000, Madras 548,874. The population may almost be considered stationary, as the death-rate is necessarily very high, although much lower than formarly.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 18TH.

UNITED SERVICES MEDICAL SOCIETY (Royal Army Medical College, Millbank, S.W.).—8.30 p.m.: Surgeon K. D. Bell, R.N.: Physical Training and the Medical Profession.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Walea's General Hospital, Tettenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meschen); Eye (Mr. R. P. Brooks). 3 p.m.: Demonstration: Dr. F. Thomson: Infectious Fevers (at the North-Eastern Fever Hospital, St. Ann's Road, N.).

THURSDAY, APRIL 15TH.

ROYAL SOCIETY OF MEDICINE (DERMATOLOGICAL SECTION) (20 Hanover Square, W.).—5 p.m.: Exhibition of Cases.

FRIDAY, APRIL 16TH.

ROYAL SOCIETY OF MEDICINE (ELECTRO-THERAPEUTICAL SECTION) (20 Hamover Square, W.).—8.30 p.m.: Dr. Sloan: Vulvo-vaginal Electrode for Ionic Medication. Mr. T. J. Bokenham: Treatment of Ulcers by Ionic Medication. Dr. Horace Manders will show an Apparatus for the Production of Continuous Oscillations.

Central London Throat and Ear Hospital (Grav's Inn Road WC).—3.45

CENTRAL LONDON W.C.).—3.45 p.m.: Labyrinth. 18. L LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, 45 p.m.: Lecture: Mr. C. Nourse: Middle Ear and Society of Tropical Medicine and Hydrene (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Dr. L. Braddon (Steremban) and Dr. A. R. Wellington (Singapore): The Ætiology of Berl-Berl.

#### Appointments.

BUTLER, T. L., M.R.O.S., L.R.C.P., District Medical Officer of the Basingstoke Union.
CURITS, G. W., M.R.C.S., L.R.C.P., District Medical Officer of the Stratton Union.
DAVIS, H., JUN., M.R.C.S., L.R.C.P., D.P.H., Certifying Factory Surgeon for the Callington District, co. Cornwall.
FORDHAM, W. J., M.R.C.S., L.R.C.P., District Medical Officer of the Howden Union.
HISLOF, J. A., L.R.C.P. and S.Edin., D.P.H., Medical Officer of the Howden Union.
HISLOF, J. A., L.R.C.P. and S.Edin., D.P.H., Medical Officer of the South Cave District, co. York.
NASH, L. G., M.R.C.S., L.R.C.P., District Medical Officer of the Newport Pagnell Union.
O'BRIEN, JOHN, L.R.C.P.Eddin., L.R.C.S.Edin., L.F.P.Glasg., Assistant Medical Superintendent of Toowoomba Asylum-Queensland.
SIMPSON, HAROLD C., L.M. and S.S.A.Lond., Medical Officer of Health, Skirlaugh Rural District Council.
THORBURN, J. C., M.B., Ch.B.Liverpool, Resident Assistant Medical Officer at the Brownlow Hill Workhouse Infirmary of the Liverpool Parish.
WALKER, A. F., I.R.C.P. and S.Edin., L.F.P.S.Glasg., District Medical Officer of Toxteth Park Township.

#### Bacancies.

BREATTICLES.

The Brown Animal Sanatory Institution.—Superintendent. Salary, £250 per annum, and £50 in lieu of residence, etc. Applications to the Secretary of the Brown Animal Sanatory Institution, University of London, South Kensington, S. W. Brixton Dispensary, Water Lane, S. W.—Resident Medical Officer. Salary, £150 per annum, with furnished apartments, attendance, coal, and gas. Applications to W. Halliday, Secretary. 2450 per annum, with quarters and free rations on the Island. Applications to the Agent-General for the Cape of Good Hope,—Leprosy Research.—Salary, £450 per annum, with quarters and free rations on the Island. Applications to the Agent-General for the Cape of Good Hope 100 Victoria Street, London, S.W.

Manchester.—Chorlton-upon-Medlock Dispensary.—Resident Medical Officer. Salary, £120 per annum, with furnished rooms and attendance. Applications to the Honorary Secretary. The Hospital for Siok Children, Great Ormond Street, London, W.C.—House Surgern Salary £30 for six months, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary. (See advt.)

The Hospital for Siok Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer. Salary £30 for six months, washing allowance £2 10s., and board and residence in the Hospital. Applications to the Secretary. (See advt.)

The Hospital for Sick Children, Great Ormond Street, W.C.—The Hospital for Sick Children, Great Or advt.)

nauv.)
The Hospital for Sick Children, Great Ormond Street, W.C.—
N.B.—There will also be a Vacancy for a House Surgeon on
the 7th June and for a House Physician on the 21st July. (See advt.)

#### Births.

CLARRE.—On April 6th, at Magor, Monmouthshire, to the wife of John Stephenson Clarke, M.B.—a son.

COPER.—On April 9th, at 27 Thornton Hill, Wimbledon, the wife of Fleet-Surgeon Edward Cooper, H.M.S. "Bellerophou, of a daughter.

Harris.—On April 5th, at Oaklands, Rochdale, the wife of Heibert Harris, M.D., of a son.

Lamplough.—On April 7th, at Bredon, Alverstoke, the wife of Dr. Wharram H. Lamplough, of a daughter.

Last.—On April 5th, at Bletsoe, Littlehampton, the wife of C. E. Last, L.R.C.P., M.R.C.S.Eng., of a son.

LOW.—On April 5th, at 18d Harley Street, London, the wife of V. Warren Low, M.D., F.R.C.S., of a daughter.

NICHOLLS.—On April 9th, at 62 Queen's Gardens, Hyde Park, London, the wife of Frank J. Nicholls, M.B., B.C., of Estbourne, of a son.

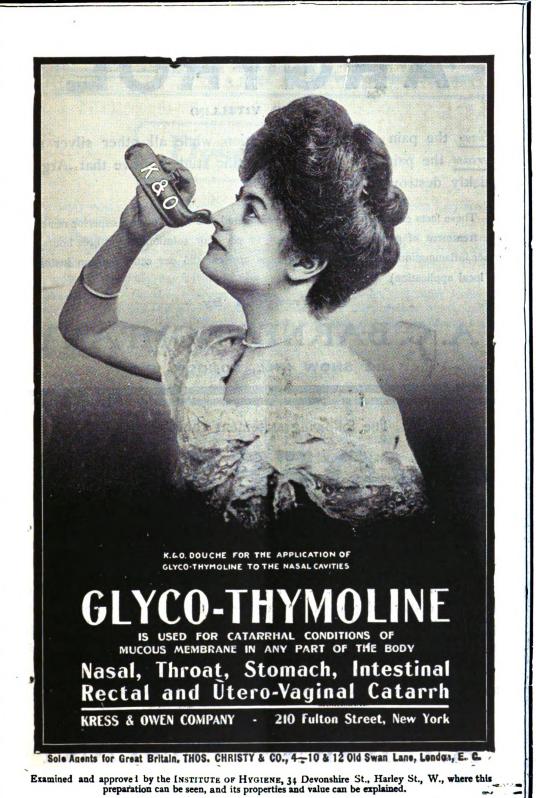
CAMERON YOUNG.—On April 4th, at Brightwell, Ipswich, the wife of Cameron Young, M.R.C.S., of a son.

#### Marriages.

WALLACE KIDSTON—FERGUSON.—On April 6th, at St. George's United Free Church, Edinburgh, Noel Wallace Kidston, M.B., Ch.B., son of the Rev. J. Wallace Kidston, 25 Earls Terrace, London, to Else, younger daughter of John Ferguson, wemyse Place, Edinburgh.

#### Beaths.

BOND.—On April 6th, at 37 Pepys Road, St. Catherine's Park.
London, Ella, wife of J. W. Bond, M.D., and daughter of the
late Colonel Edward Ramsden Priestley.
CRAWFORD HATES.—On April 5th, Thomas Crawford Hayes, M.A.
M.D., F.R.C.P., of 17 Clarges Street, Mayfair, London.
WEBS.—On April 8th, at 113 Maida Vale, London, Frederick
Ernest Webb, M.R.C.S., L.R.C.P., son of the late Thomas
Ernest Webb, formerly of Bungay, aged 77.



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Probably most cases of indigestion are due to the inability to convert amylaceous foods into assimilable forms.

Taka-Diastase has been proved to be the most potent—as well as the most convenient—substitute for ptyalin and amylopsin when these are deficient. It is a pure vegetable amylolytic ferment, capable of rendering soluble 150 times its weight of dry starch in ten minutes, and much more in a longer period.

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#### BIBLIOGRAPHY.

AMYLACEOUS DYSPEPSIA. In no case did I find Taka-Diastase fail in giving good results. —Lancet, August 7th, 1897.

DYSPEPSIA. Excellent results in many obstinate cases.—Liverpool Med. Chir. Jour., January, 1897.

GOUTY DYSPEPSIA. Most gratifying results after everything else had failed.—Lancet, October 10th, 1903, page 1052. Also see The Practitioner, February, 1907, page 168.

TUBERCULOSIS. A powerful aid to nutrition and increased strength.—Medical Magazine, June, 1906.

chronic constipation. Often brings about a cure in the most obstinate cases. — Therapeutic Gazette, October 15th, 1906.

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—Therapeutic Gazette, October 15th, 1906.

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## THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, APRIL 21, 1909.

No. 16.

## Notes and Comments.

Christian Science at Sutton.

CHRISTIAN Science can hardly be congratulated on the show that it made in the case reported last week from Sutton. A Miss Latour, from Guatemala, had the misfortune to

contract tuberculosis of the lungs when living at Kew, when she was attended by Dr. Bellamy, and under his treatment she made considerable improvement. Here, then, was the opportunity for the Christian Scientist to step in and complete the good work Dr. Bellamy had begun. Unfortunately for the cult, the improvemnt was not maintained, and Miss Latour left her home and went to stay with friends at Sutton, "to get away from doctors"—to use her own expression. The disease progressed, her friends became alarmed, and Dr. Hooper of that place was sent for. He was politely informed on arrival that he was sent for "to keep within the law." Naturally and very properly Dr. Hooper declined to play the part of scapegoat, and advised that Dr. Bellamy should be sent for, if medical attendance were needed. In evidence at the inquest, Dr. Bellamy explained that when he ceased his attendance there was no active tuberculous disease, and that he held that no medical man should give a certificate under the circumstances. The friends had told him that there was no such thing as pain and no such thing as death. Un-happily in the case of the deluded lady the latter opinion was disproved by the sequence of events, as she passed away shortly afterwards.

A Qualified Success.

AFTER hearing the evidence at the inquest, the Coroner's jury found that death was due to natural causes, and that there had been no criminal neglect on the part of any-

one, the friends having done their best according to their belief. But they added a rider to the effect that they were of opinion that, had Miss Latour received proper medical advice, instead of trusting to Christian Science treatment, her life might have been considerably prolonged. This strikes us as being as sensible and scientific a verdict as could be given under the circumstances. The folly and chicanery of Christian Science will find a natural quietus if left to expend themselves on the weaked-minded and more credulous portion of the community. The flames of "persecution," police court and assize proceedings, and so on, are only calculated to give a lurid advertisement to a procedure which, while partaking of both elements. inclines more to silliness than crime. In really bad cases of neglect, criminal steps may be necessary, but in cases such as that of the unfortunate Miss Latour, in which an adult person has been blinded and led away by the sophistries and pompous

platitudes of Christian Science practitioners, it is impossible to blame anybody who survives the catastrophe, except the practitioners. And while unqualified practice is allowed by the law, it is only inviting odium and suggestions of self-interest to advocate criminal prosecution of practitioners of the cult.

Accident Hospital.

An interesting little medical dispute is being carried on at Barry. That place owns what is described as the only hospital in the United Kingdom maintained wholly out of

the rates—a description which is hardly accurate when one considers the large number of fever hospitals throughout the country which are rate-supported. Such hospitals differ from the Barry hospital, however, in that, whereas at the former there are special salaried medical officers, at Barry the medical staff is honorary. The argument has been adduced that, under the circumstances, all medical men in the town should be members of the staff, or, at least, should be able to attend their own patients when inmates of the institution. right is claimed by them as ratepayers. As it is, there is a special staff to which, as the members are *ipso facto* hospital surgeons, a certain prestige is attributed. The point was considered by the local division of the British Medical Association, which decided in favour of the application. The matter was then referred to headquarters, and efforts were made to ferred to headquarters, and efforts were made to effect a compromise, without, however, securing The matter has been referred to the Hospital Committee of the Association. We cannot say that, in the absence of special knowledge, we are competent to express a decided view one way or another, but it seems to resolve itself largely into a matter of local convenience, for we conceive it possible that, with a large number of honorary medical officers, the administration of the hospital would be very difficult to carry out efficiently.

What is Brandy?

THE question, "What is brandy?" seems determined to agitate society for some time to come, much in the same way as the equally vexed question concerning whisky. In the evidence taken before the Royal Commission

on whisky and other potable spirits, the proper definition of brandy has taken a prominent position. One gentleman took the ground that analysis should always be made the supreme test of procedure, as it is at present. In support of that view he advanced the interesting but imperfect analogy of the difference between Welsh and Australian mutton, which could not be determined by chemist's analysis. In the same way he did not think that

laboratory investigation could settle whether a given brandy came from Cognac or not. So far as medicine is concerned, the definition of French brandy has long since been fixed under the heading of "Spiritus Vini Gallici" as "spirit distilled from French wine." Later, in 1898, it was further French wine." Later, in 1898, it was further described as "a spirituous liquid distilled from wine and matured by age. and containing not less than 36½ per cent. by weight, or 45½ per cent. by volume, of ethyl hydroxide." The fact of these variations from time to time in the Pharmacopæia definitions clearly shows that the compilers' views were liable to alteration. When brandy is ordered as a drug their view must be final, and it doubtless expresses their opinion as to what constitutes brandy when not ordered as a drug.

#### Featureless Brandy.

DR. LETHERLAND TEED, the wellknown analyst and authority upon drugs, stated that although he had never tasted or analysed mistura spiritus vini Gallici, yet he under-

stood it to be a kind of egg flip. Although Cognac brandy was still being imported, he understood that large quantities of wine were being turned by a process of fractional distillation into featureless spirit. If such a product was recognised as brandy it would be impossible for an analyst to distinguish between it and other featureless spirits made from beetroot, molasses, potatoes, corn, and so on, which it was well known were being palmed off on the public as brandy. Dr. Teed's view of brandy is of importance. He defines it as a spirit distilled from the produce of the grape in a pot still. The word "brandy" occurred in an Act of Parliament 100 years ago, when there were no fractionalising or patent stills. It seems likely that most medical men will heartily endorse Dr. Teed's claim that those who ask for brandy should be entitled to a spirit distilled from wine in a pot still A further safeguard could be obtained by a Government stamp guaranteeing the origin of all such spirit, were such a thing practicable.

Our New Army Column.

WE have much pleasure in calling the attention of our readers to a new feature in our correspondence. A reference to page 411 will show a column under the head-

ing of "Military and Naval Medical Notes," which will in future appear weekly or otherwise, as circumstances may require. The contribution comes from the pen of a distinguished military correspondent, in whose trustworthiness and accuracy of information we place implicit reliance. From long experience we fee! confident that this new departure will be welcome to a large number of readers who are interested in military and naval matters in various parts of the world, and whom it is difficult to keep in comprehensive touch with that particular branch of medical life otherwise than through the agency of a specially qualified correspondent. We need hardly add that authentic military and naval news will always be a welcome contribution to the Editor's box.

#### LEADING ARTICLES.

#### PAY PATIENTS AND VOLUNTARY HOSPITALS.

THE question of the relation of the voluntary medical charities to the medical profession has been a matter of recurrent controversy for at least a couple of generations. That the matter has never

been brought to a head is possibly, or probably, due to the lack of effective organisation on the part of medical men. To some extent the latter defect is being remedied, and it is to be sincerely hoped that, with the development of a common collective policy and effectual basis of action, the question of the proper relation of charitable hospitals to the medical profession will be amicably and impartially decided. It is to be regretted that the powers of the General Medical Council do not permit of that august body dealing with a matter in which the welfare of the medical profession is so intimately concerned. There are other professional organisations, however, to which we may turn for help. notably, the various defence unions and the British Medical Association, which has of late devoted a not inconsiderable amount of attention to the question. The publication of a "warning notice" concerning certain vacant hospital and other appointments marks a practical step in the direction of the principle of collective defence and protest. It may be hoped that the Association will before long take into serious consideration the question of the payments of patients to voluntary hospitals. If there be any truth in the outcry of the general practitioner against hospital competition, it is obviously multiplied and materialised when presented in the shape of a paying patient in the wards of a hospital built, organised, endowed and maintained by money given by charitable persons for the specific object of relieving the sick poor. To use charitable funds, earmarked for that clearlydefined object for the purpose of making profit raises a delicate legal question as to the responsibility of the governing board that sanctions such a transaction. The whole matter of paying patients was discussed by a speaker at the London Nursing and Midwives Conference, held in London last week. Amongst other things, he pointed out that, whereas the poor and the rich were able to get the best possible modern medical treatment, the one in well-equipped voluntary and State hospitals and the other in private nursing homes, the middleclass individual of moderate means, on the other hand, was inadequately provided for. Practically, in time of sickness, such a patient was obliged to face his illness at home or to resort as a free or a paying patient to a hospital. The disadvantages of the first-mentioned courses are obvious, while the third involves injustices of various kinds that have long been recognised and protested against by the general practitioner. When a patient capable of paying moderate fees resorts to the pay wards of a voluntary charity, he is giving rise to a threefold injury. First, he is displacing a poor person, that is to say, one of the very class for whom the hospital was primarily provided; secondly, he is depriving the outside medical practitioner of a source of income to which he is justly entitled; thirdly, he is placing the board of governors of the particular institution to which he hands his money in the invidious position of diverting charitable trust funds from their original purpose. While the motives of hospital authorities are transparently honest, and their sole object is obviously to add to the funds of the charity with which they are connected, it is nevertheless fairly apparent that their action may involve them at any moment in an

undesirable position as regards their legal responsibilities. The suggestion of the speaker at the Conference that the legality or otherwise of patients' payments to voluntary hospitals should be made the subject of a friendly test action is well worth serious consideration. It is difficult to imagine any way of arriving at the truth of the matter otherwise than by a formal decision of the law courts. The friendly test action is a means of defining doubtful powers and responsibilities that is often resorted to by executors and heirs of estates. There is no apparent reason why it should not be adopted in the present instance. Either the patients' payments to voluntary charities are legal or not legal. If shown to be legal, members of hospital boards that accept such payments may continue the practice with confidence; if not legal, then they will take steps forthwith to put an end to the system, and a rock of offence will be removed from the path of the medical profession. It was further suggested that the friendly test action might come with advantage from either one of the Medical Defence Unions or the British Medical Association, and the suggestion appears to be an excellent one. By this simple expedient it is not impossible that the whole of the longstanding dispute between the voluntary charities and the medical profession would be settled out of The precise method of bringing such an action could safely be left to the lawyers to arrange. All that the test action would propose to ascertain is whether the acceptance of payments by patients by a voluntary medical charity, where such payments have not been expressly sanctioned in the document of foundation, does or does not constitute a misdirection of a charitable trust. If the matter be put in a reasonable and temperate way to the board of management of any great hospital that has adopted the principle of pay wards, it is not improbable that they would willingly accept the opportunity of defining their exact powers, and possibly of escaping from a false position of which the consequences might at some future time prove of an embarassing nature. From many points of view the suggestion of the test action meets the wants of the case in a peculiarly appropriate way. The idea is too good to be lost, and it is to be hoped that before many months are gone by, either the British Medical Association or some other professional body will have taken steps to reduce the suggestion to a practical issue.

#### MEDICAL MEN AND FRIENDLY SOCIETIES.

LAST week the Annual Conference of the Friendly Societies' Medical Alliance was held at Darlington. This Alliance comprises the medical associations which exist in connection with the great friendly societies throughout the country, and once a year representatives from each gather to discuss questions of mutual interest. These questions are so closely associated with one phase of medical practice that the profession cannot afford wholly to neglect the views held by the Alliance, whether or not it agrees with them. The President for this year, Mr. J. E. Wood, of Darlington, gave the customary address, and stated the line which, in his view, the Alliance should take in regard to the matters of controversy before it. We gather from what was said that the medical associations are

not so numerous nor so powerful in the North of England as in the South, for it seems that the Darlington Association is only seven years old, yet stands fifth in point of numbers of those affiliated to the Alliance, and Mr. Wood dwelt on the necessity of co-operation and combination if the movement were to grow and be placed in a secure position. He then proceeded to discuss the burning question of their relations with their medical officers, and he admitted that forces were still operating against them. Now, for the friendly societies we can truthfully say that we entertain a sincere admiration. The members are drawn for a large part from that excellent class in the community, the hard-working artisan, and their affairs are managed, as a whole, with a prudence and administered with an intelligence which are calculated to show that all wisdom does not reside in the classes which have no need of the aid of such societies. Founded on the principle of thrift, and taking a stand independent of State aid, the friendly societies stand as a model of what can be done by mutual support among the workers of the country. We cannot help regretting that the Government were not able to make the receipt of a society's pension a qualification in itself for receiving the five shillings a week which now is given only to those who have no assured source of income. Yet, while regarding the societies with all friendliness, we must join issue with them with regard to their medical policy, and we are glad to hear the President admit that "forces" operating against them on this score. the first place, we are surprised that the members are unable to recognise the fairness of insisting on a wage-limit in dealing with the members who contract for medical attendance. It is possible for anyone, whatever his income, to join a friendly society, and by keeping up his payments to be entitled to medical attendance whenever he is ill. Now, it is generally recognised that these societies are so stable and form so good an investment for surplus money, that many people of quite good position join them, and thereby become entitled to their benefits. While it is fair and just that a man should draw sick pay in proportion to the premium he pays, it is neither fair nor just that a member of a society can obtain medical attendance at Friendly society rates when he can well afford a doctor's normal rate of fees. Doctors, like other business people, have to take work in bulk more cheaply than when it comes in driblets, and they are able to make a low rate of charge to members of friendly societies for that reason among others. But the story by no means ends there. The whole theory of medical fees is that a person shall pay according to his means, and a well-to-do patient gets just the same advice for half-a-guinea as a poor man at half-a-crown. The system may be illogical, but if a better one can be suggested we shall be glad to learn it. Certainly, it is not that because a doctor is prepared to make special rates for people unable to pay adequate fees that he shall take everybody who likes to join with them at the same inadequate figure. The argument has only to be stated to bear its own refutation. No doubt it is a great incentive to people to join friendly societies that they know they can get

their medical attendance for a few shillings a year, but in the case of the better-to-do, who can afford a doctor's ordinary fees and yet wish to join a society, it is quite possible to exclude them from medical benefits, or to impose a higher rate on them. It is a great advantage to a friendly society to contain not only the artisan class, but most of the well-to-do tradesmen and clerks in a neighbourhood, but that advantage should be gained by the inherent soundness of the financial position of the society, and not by offering the special terms for which a medical man is prepared to attend the poorer members. Mr. Wood admitted that there was room for improvement between some associations and their medical staffs, but while he counselled that these difficulties should be dealt with in a sympathetic manner, he stood for a pretty uncompromising assertion of the rights of the societies. It is particularly significant that a resolution that "this Conference cannot at any time recognise any decision accepting a wage-limit for the attendance of a friendly society doctor" was passed without discussion. While such is the attitude of the Conference, we fear the end of the friction is yet a long way off.

#### CURRENT TOPICS.

The Value of Meat Import Regulations.

THE value of the recently-introduced legislation anent the regulation of meat imports has been amply vindicated by the report of Mr. James McPhail, Chief Food Inspector to the Hull and Goole Port Authority. In his first recital of his experience of the third section of the Public Health (Foreign Meat Regulations) Act, 1908, he reported extensive seizures of unsound meat from the Continent. Much of this pernicious stuff bore the label of the Government of the source of origin entitling it to be admitted, but large quantities thus guaranteed as wholesome were exported or destroyed as unfit for human food. The details of the seizures are reassuring as regards the vigilance of the inspectors and the value of the Act, but they are, on the other hand, extremely disquieting as indicating the mass of dangerous infection that must year by year be sent into our ports by unscrupulous foreign meat importers. In one case a quantity of so-called sausages sent in a barrel from Copenhagen were found to consist of scrap meat stuffed into the large bowel of an ox! Of four unlabelled pigs, one carcass was tuberculous and had the glands of the neck removed; another showed peritonitis; a third had the vertebræ badly formed and there had been dropsy. During the quarter large quantities of offal from calves, sheep and pigs were landed at Hull bearing the Government inspection mark, which was supposed to guarantee it as fit for food. The inspectors found large numbers of livers affected with parasites, such as immature tape-worms and flukes. One of the most important matters arising out of the Hull report appears to be the fact that, Liverpool having obtained through the Local Government Board a relaxation of the restrictions, the inevitable consequence of any such inequality would be to divert the meat trade from Hull and other stringentlyguarded ports to Liverpool, with results that could hardly fail to be inimical to the national health. The supreme importance of an absolutely uniform administration of the Act by port authorities is obvious, and the report of Mr. McPhail may be commended to the careful attention of the Local Government Board.

Compulsory Irish at the National University of Ireland.

THERE is in Ireland at the present moment evidence of the existence of a tendency on the part of many, otherwise level-headed men, to allow their sentiments to outrun their practical instincts. Perhaps in other countries, where everything gives way to the exigencies of material prosperity, some of this tendency would be no disadvantage, but in Ireland, of all places, where sentiment has always run rampant, it is far more necessary to decry than to encourage its exaggeration. For this reason we welcome the utterances of General Sir William Butler at the prize-giving ceremony at Rockwell College during the past week. Speaking of the possibility of supplanting English by Irish in Ireland, he drew attention to the fact that in Ireland they were within four hours' steaming on one side and four days' steaming on the other side, of millions of English-speaking people. He did not see, therefore, with these enormous masses around them, who for all purposes of life and all professions only knew the one tongue, it would be practicable to make such a change. On the other hand, he saw no reason why Irish should not take the place that Latin did in the Middle Ages, when it too ceased to be the language of the mart and of commerce. He was no believer in compulsion, and he did not understand why this country (Ireland), which had been for eighty years protesting against compulsion, should now advocate it. Is it too much to hope that Sir William Butler's practical utterances will produce the effect their importance warrants?

#### A Sanitary Oath.

For years past we, in common with the rest of the British medical oress, have been preaching against the ordinary form of taking the oath by kissing the book. A more offensive object to approach to the lips than the Testament generally proffered to witnesses in petty sessions or coroners' courts one can scarcely imagine. Smeared with the grease of decades, inoculated with the infections of thousands, it is hardly questionable that diseases of the most noxious description have been transmitted by its agency. To mention no others, syphilis, diphtheria, and influenza must frequently have been transmitted in this way. It seems likely, however, that all this will soon be changed. The Oaths Bill, which passed through the Standing Committee of the House of Commons before the recess, aims at substituting the Scottish form of oath for that by kissing the book. This form-taking the oath with uplifted hand-has for a considerable time been a legal alternative to the other in our courts of justice. The Oaths Bill, however, seeks to make it the only legal form, and to ensure that the oath shall always be administered in the same way. It seems quite likely that the Bill will become law, and thereby put an end to a custom at once revolting to taste and dangerous to health.

Nursing in India.

WE are glad to learn that that excellent institution, Lady Minto's Nursing Association, continues to flourish and to be appreciated by the Anglo-Indians of Northern India and Burmah. In old days, Indian residents who fell sick suffered much from the need of skilled nursing, and it is now a good many years since the Up-Country Nursing Association was started to provide skilled nursing for the English in Northern India. The work of the Association rapidly increased, and a few years ago, owing to the interest shown by the wife of the Viceroy, its scope was greatly enlarged, and the title of the Association changed. The Association is most careful in its choice of nurses, and, we understand, pays them adequate remuneration, and sees that they are comfortably housed. At present three superintendents and forty-four nurses constitute the staff. Last year 338 cases were attended, of which 103 were cases of enteric fever. The income of the Association is in part derived from fees earned by the nurses, and in part from voluntary contributions from subscribers, who pay according to their salaries, and have first claim on the services of the nurses, and at a lower rate than non-subscribers.

The Tuberculosis Campaign in Ireland.

It is now several years since the project of erecting a joint sanatorium for the County and City of Cork was first inaugurated, at the instance of the local branch of the National Association for the Prevention of Tuberculosis. Many unforeseen difficulties arose, chiefly springing from the question of a suitable site, and for some time it seemed as if the project would have to be abandoned. Last year, however, owing to the generosity of a member of the Joint Committee, Mr. Brazier-Creagh, a free site, with two hundred acres of land, in a suitable situation as regards soil and shelter, was presented to the committee. Last week her Excellency the Countess of Aberdeen carried matters a step further by laying the foundation-stone. All the sanitary authorities of the county and city-twenty-eight in number-are contributory to the scheme. It has been decided, for reasons with which we are unacquainted, to erect one compact building rather than a series of chalets. The total outlay is expected to be about £12,000, and accommodation will be provided for seventy-seven patients. Cork is the first county in Ireland to found a sanatorium, and the experiment will be watched with interest, since there is some risk that the importance of preventive work may detract attention from curative measures.

#### PERSONAL.

AT Haslar Hospital the following distinctions have been conferred on the class of Surgeons-on-Probation: The Gold Medal on Surgeon McW. A. H. McKirrow, M.B., Ch.B.Aber.; the Microscope on Surgeon F. G. Hitch, late of the London Hospital; and the Silver Medal on Surgeon J. Glaister, M.B., Ch.B.Glasg.

- DR. MATTHEWS BROWNE has been appointed a Justice of the Peace for the Borough of Eastbourne by the Lord Chancellor.
- MR. H. A. T. FAIRBANK, M.S., F.R.C.S., of Charing Cross Hospital, has been appointed Surgeon to the Miller General Hospital.

THE Hon. John McCall, M.D., has been appointed Agent-General for Tasmania in this country. He enters on his duties on May 1st next.

- DR. ARRIGO TAMASSIA, Professor of Forensic Medicine, at the University of Padua, has been appointed by the King of Italy to be a Senator of the Kingdom.
- Dr. A. S. BOSTOCK, of Chichester, has received a handsome testimonial and cheque from a large number of friends and patients on retiring from practice in that town.
- DR. JOHN CUTHBERTSON, of Droitwich, and Dr. Cordley Bradford, of Acocks Green, have been appointed Justices of the Peace for the County of Worcestershire.
- Dr. F. M. SANDWITH, Gresham Professor of Medicine, is giving a series of lectures this week, at Gresham College, on "Cancer," and also on some tropical diseases.
- DR. FRANZ RITTER VON HABERTER has been appointed to the posts of Ministerial Councillor and Medical Referee to the Austrian Ministry of the Interior, to succeed the late Dr. Daimer.

THE Lccal Government Board have approved the appointment by the St. Pancras Borough Council of Mr. J. K. Colwell as local Public Analyst in succession to the late Sir T. Stevenson, M.D.

WE regret to record the death, after a prolonged illness, of Lady Brunton, wife of Sir Thomas Lauder Brunton. We are sure that the sympathy of the profession will go out to Sir Thomas in his great bereavement.

THE LORD MAYOR, accompanied by the Sheriffs, will visit St. Bartholomew's Hospital on Friday, May 7th, at 3 p.m., to open the new Pathological Blocks. The ceremony will take place in the Great Hall of the Hospital.

PROFESSOR G. R. MURRAY, of Manchester, will open a discussion on "Diseases of the Thyroid Gland" at the Hunterian Society to-night at 8.30 p.m. Sir Victor Horsley and Mr. James Berry have promised to take part.

THE delegates of the Common University Fund of Oxford University have appointed Dr. Joseph F. Payne, Honorary Fellow of Magdalen College, to give six lectures on "The History of Greek Medicine up to the Age of Hippocrates," at the schools, on Wednesdays and Fridays, at 5.45 p.m., beginning on May 5th.

- Dr. David M'Kail, M.D., D.P.H., has been appointed by the Governors of St. Mungo's College, Glasgow, lecturer on Forensic Medicine and Hygiene, and also cn Public Health, in succession to Dr. Hugh Galt, Dean of Faculty in St. Mungo's College.
- SIR WILLIAM MCGREGOR, the newly-appointed Governor of Queensland, entered the Colonial Office service as Government Medical Officer at Mauritius. He was next promoted to Fiji, and it was while here, now over a quarter of a century ago, that he caught the eye of Lord Stanmore. From Medical Officer his administrative ability secured for him the Governorship of British New Guinea, where he remained for ten years. Thence he was appointed to Lagos, and after his term of office there he was appointed to Newfoundland.

## A CLINICAL LECTURE

ON

#### RENAL CALCULUS.

By ANDREW FULLERTON, M.D., F.R.C.S.,

Honorary Assistant Surgeon to the Royal Victoria Hospital, Belfast, and to the Belfast Hospital for Sick Children.

PART I.

GENTLEMEN,—The atiology of renal calculus is somewhat obscure. It may be that a foreign body, somewhat obscure. It may be that a foreign body, a little piece of necrotic tissue, a minute blood-clot, a parasite, or some substance or body abnormally situated in the kidney, may give rise to a nucleus, which, when once formed, tends to increase in size and become a calculus. Ebstein believes that the first step in the development of a calculus is the formation of an organic framework. The composition mation of an organic framework. The composition of the urine is probably of more importance. Thus, an alkaline condition of urine predisposes to the formation of phosphatic calculi, the urine of a gouty person is liable to deposit uric acid, and there are certain conditions of ill-health in which crystals of oxalate of calcium are liable to be deposited from the urine. Again, it is well known that in certain districts stone is much more common than in others. In tropical countries, where a large portion of the moisture of the body is got rid of by evaporation, the urine is likely to become concentrated, and to deposit some of its more insoluble constituents. In India, for instance, stone is one of the most frequent complaints that the surgeon is called upon to freat. In the North of Ireland, from which we draw most of our clinical material, stone cannot be said to be very common. The affection is certainly met with more frequently in some parts of England than it is with us. It is likely, also, that certain articles of food and drink may predispose to the development of calculi. In this connection it is only necessary to mention wines, hard drinking water, and vegetables, such as sorrel, rhubarb, &c., which contain calcium oxalate.

Origin of Renal Calculi.—Calculi originate in the kidney or in its pelvis. In new-born children, a granular deposit, composed of urates, is frequently found in the kidneys, but this is soon washed away when the urinary function is properly established. In a similar way, in later life, small particles of undissolved salts may be deposited in the kidney or its pelvis, and fail to be washed away, thus giving rise to a stone which, when once formed, tends to increase, until it may attain a very considerable size. As a rule, it rarely exceeds a small marble in size, but stones which entirely fill the renal pelvis and calyces

are occasionally seen.

Chemical Composition.—Renal calculi may be divided according to their chemical composition, into three great groups. Those of the first group are composed mainly of uric acid or urates; those of the second group, of oxalates; and those of the third group, of phosphates. In addition to these common varieties, calculi composed of cystin, calcium carbonate, and some other substances, are, in rare instances met with. It is generally stated that uric acid calculi are those most commonly met with; but from my own experience, I should be inclined to give the premier place to those composed of oxalate of calcium. It must be understood that these calculi are not infrequently mixed in composition, uric acid, for instance, being often associated with oxalates or phosphates. Similarly, a calculus composed principally of calcium oxalate may be mixed with uric acid, urates, or calcium carbonate. Phosphatic calculi, likewise, are rarely pure. It is well to have a simple test to differentiate the various calculi usually met with, and I have found the following method, which

is in common use, satisfactory. The calculus is cut and a scraping is taken from each layer. To this isadded a little water in a test-tube, and heat applied. If the fragment dissolves, it may be urates, cystin, or xanthin. If it does not dissolve, it may be oxalates, phosphates, or carbonates. Add a few drops of HCl, and heat. If it dissolves with effervescence, it is composed of carbonate; if it dissolves without effervescence, it is either phosphate or oxalate. Now add a few drops of ammonia solution. If a precipitate forms and is re-dissolved by acetic acid, phosphate is present. If the precipitate is not re-dissolved by acetic acid, oxalate is present. If the scraping does not dissolve either in water or in HCl, add to it a few drops of HNO<sub>3</sub>, and evaporate to dryness in a porcelain capsule. A yellowish-red residue rendered violet by ammonia solution, or dark blue (disappearing on heating), on the addition of caustic potash or soda; denotes uric acid. Uric acid, urates, cystin, and xanthin completely melt away on heating on platinum or mica foil. If cystin be present, the characteristic: crystals may be seen on evaporating a solution of it in water.

Characters of the Calculi.—The uric acid calculus is smooth or finely granular, is hard in consistence, and is of a yellow, reddish brown, or greyish colour. Oxalate calculi are brown or grey in colour, and may be mulberry-shaped or smooth. They are hard in consistence. Phosphatic calculi are white, and relatively soft. Cystin calculi are generally small, smooth, round, and yellowish or white in colour. They are soft, and on section show a white lamellated appearance. Xanthin calculi are brownish or reddish, smooth, hard, and lamellated on section.

The size and shape of renal calculi are influenced, to a large extent, by the cavity in which they are developed. Those which are formed in the calyces or pelvis of the kidney are moulds of these parts, and, consequently, round or branched in form, while those which have been long in the ureter are likely to be narrow and elongated. If several calculi are present, they may present facets at the points of contact.

Effects of Calculi on Surrounding Tissucs.—A calculus acts as a foreign body, and, consequently, irritates the tissues in which it lies. If it remain aseptic, chronic inflammatory changes occur in the renal parenchyma. If, however, sepsis occurs, suppurative pyelitis or nephritis may take place and go-on to complete destruction of the kidney. The least that is likely to happen is a localised interstitial nephritis. If the calculus produces obstruction, hydroor pyonephrosis may result, or the kidney may undergo complete atrophy without dilatation. A pyonephrotic kidney may leak into the surrounding tissues, giving rise to a perinephritic abscess. This may discharge externally or into the intestine. The other kidney may, if healthy, hypertrophy or become infected from the bladder. If already calculous like its fellow, if will run great risks of ascending infection from the blackler. This has an important bearing on treatment. The presence even of an aseptic stone is a menace, not only to the affected kidney, but also to the sound one. Statistics were collected by Legneu, who showed that in 50 per cent. calculi were present in the opposite kidney, while in the remaining cases, the second kidney was affected by sclerosis, or suppuration, or hypertrophy, or atrophy, or cystic degeneration, or some combination of these processes. Further, prolonged

suppuration in one kidney is likely to give rise to

amyloid changes in the opposite one. Symptoms of Renal Calculus.—A case upon which I recently operated in the wards is a fair example of this condition. He was a male, æt. 29. Last September, he had a severe pain in his right lumbar region which radiated down the front of his abdomen and into his right testicle. The attack lasted several hours. From this period up to February, he had attacks about every month, but since February he had had them every fortnight. During the attack, he complained of frequency of micturition, but says that there was no blood in the urine. The specimen of urine which he supplied looked clear, but on microscopical examination, blood cells were found in small quantity. On cystoscopic examination, the right ureteric orifice was seen to be rounder and larger than usual, with many small blood vessels surrounding it. The urine from this orifice contained a fair quantity of albumin, and numerous blood corpuscles. Its specific gravity was 1010, and its reaction acid. The specimen from the left side was also acid, and conspecified a trace of albumin. It was, however, free from blood, and had a specific gravity of 1015. The quantity ejected from the right ureter was greater than that ejected in the same time from the left. I have elsewhere (a) drawn special attention to this increase in the quantity of urine with diminished specific gravity in cases of renal calculus. It is a useful corroborative sign. At the operation, I found a large oval, brown, spiculated stone in the renal pelvis. I cannot understand how he had so little bleeding, as the surface of the stone, which was composed of oxalate of calcium, was rough as a file. The symptoms in this patient were comparatively mild when one considers the size and roughness of the stone. In another case, which I saw a few days later, the patient, a young lady, had more severe symptoms. She had vomiting during the attacks, and the pain, besides radiating towards the groin, extended down the outer side of the thigh. The attacks were also attended with fairly free hæmaturia. Here, again, the specific gravity of the urine on the affected was low-1005-as against 1015 on the sound side. In another case, the pain radiated down the outer side of the thigh to the great toe. In this case, again, the specific gravity was low on the affected sideunder 1005, as against 1015 on the sound side. In one or two of my cases, the pain was so severe as to cause symptoms of collapse. Several stated that they did not pass any urine during the attack, but that on its subsidence, a large quantity was passed. A youth upon whom I have just operated, had become a wreck from the frequency and severity of his attacks. His stone, a small uric acid calculus, was lodged in his ureter near his bladder, and was almost missed at the operation. I explored his kidney and its pelvis by a very free incision into the former, but no trace of a stone could be seen or felt. The ureter was palpated as far down as possible through a large lumbar wound, with a negative result. Finally, a long ureteral catheter was passed into the bladder from the kidney, and on withdrawing this the stone was dragged up into the pelvis of the kidney, and easily removed. In this case I noticed, during the operation, that the kidney was smaller than normal, and its behaviour to sulphindigodate of soda, previous to operation, was peculiar. We found that whereas in less than half-an-hour the sound kidney was excreting deep blue urine, the affected kidney did not commence to do so for at least a quarter-of-an-hour later. I have drawn your attention, so far, to fairly typical cases with well-marked symptoms, but it must not be supposed that all cases are so easily diagnosed. A year or two ago, a man was sent down to me from the medical wards, suffering from hæmaturia only. It was not clear from his symptoms whether the blood came from his bladder or from his kidneys. On cystoscopic examination, bloody urine

was seen to come from the left ureter, and on exploration, a minute, needle-shaped oxalate of calcium calculus was removed from the kidney. Cases like this are, however, rare. Generally, pain is associated with the hæmaturia. I have recently operated on a case of renal calculus in which there was neither pain nor hæmaturia. The patient stated that there had been some pain two years previously in the region of one ovary, but was confident that this was not connected with the present illness. She had symptoms suggestive of cystitis for a few weeks, but these passed off, leaving, as the only symptom, copious pyuria. At the operation, we found that she had a rough oxalate of calcium stone, completely filling the ureter at its junction with the pelvis of the kidney. A small channel on one surface of the calculus allowed the urine to trickle past the obstruction. There was. however, sufficient obstruction to produce a pyonephrosis, and there were also small abscesses in the remains of the cortex, so that I was obliged to remove the kidney. I had previously satisfied myself that the other kidney was in a condition to carry on the urinary secretion in a satisfactory way. From a study of these cases you will be prepared for the following classification of symptoms

-The pain which is produced by a renal calculus varies within wide limits. An aseptic calculus may lie quietly in the substance of the kidney without causing pain, or, at most, may give rise to an aching feeling which is often ascribed to rheumatism or lumbago. It is much less likely to be so free from symptoms if it is in the pelvis of the kidney. If the calculus is free to move, it soon makes itself felt by becoming engaged at the outlet of the pelvis. The most typical attacks of renal colic are produced by the passage of a stone along the ureter into the bladder. An intense and sometimes agonising pain is suddenly felt in the lumbar region. This extends along the course of the ureter and may involve the bladder, the inner or outer surface of the thigh and leg, even to the toes. At the same time it may extend to the testis of the affected side, or to the glans penis. It may even radiate to the abdominal viscera. agony may be so great that beads of cold sweat break out, and the pulse becomes small and rapid. Nausea and vomiting may occur, and the patient may lose consciousness. He may at this stage have frequent micturition, with straining to pass a few drops of bloody urine. This is called strangury. If sepsis be present he may in addition pass pus and mucus, which add to his distress by causing severe scalding of the urethra. If the stone blocks the ureter, the urine that is passed, being from the healthy ureter, may be free from pus or blood. Between the extremes of pain that I have mentioned, all degrees of distress may occur. The attack may suddenly cease by the calculus entering the bladder, or being displaced from the orifice of the ureter. While these attacks are fairly characteristic of renal calculus, they may be closely simulated by other conditions. Last summer I saw what appeared to be a typical case of renal calculus turn out to be an appendical abscess. Again, there are other conditions of the kidney which give rise to similar attacks, notably movable kidney, tubercle of the kidney, hydronephrosis, tumours, and acute congestion.

Hæmorrhage.—A very frequent symptom of renal calculus is hæmorrhage. It may, as Î have shown, be microscopical in amount, or it may be so profuse as to render the urine a bright red in colour, and it has even proved tatal. As a rule, however, the quantity is moderate, and colours the urine a dark red or brown. I must warn you, however that too much dependence must not be placed on the colour of the urine, as indicating its source of origin. I was recently asked to examine a patient with a view of ascertaining which kidney was affected. He was passing dark brown urine. On cystoscopic examination, we found that neither kidney was affected, but that a large carcinomatous ulcer of the bladder was the cause of the hæmorrhage. I have already pointed out that hæmorrhage may be the only symptom of stone present. It occasionally happens, however, that this symptom may be entirely absent, as in a case that I operated on a few months ago. This patient's urine was repeatedly examined by her husband, who was a medical man, but neither blood nor pus was found. I made the diagnosis chiefly from the pain and the specific gravity of the urine from the affected kidney. The X-rays, usually a most valuable means of diagnosis, failed in this case to discover the stone, which, though small, gave rise to very severe symptoms. The removal of the calculus was attended with complete relief of her symptoms.

Pyuria.—This symptom may be present in conjunction with blood and mucus. In the case to which I referred in the earlier part of this lecture, the only sign was pyuria. In most cases of stone, especially when the calculus is situated in the pelvis of the kidney,

there is pus in the urine.

Anuria.—Anuria may occur if by any chance both ureters are blocked by calculi, or if one ureter is obstructed and the other kidney is wanting. It is now, however, generally admitted that reflex anuria may occur. If one kidney be injured the secretion of both kidneys may cease, and fatal results may follow in this way from an operation for renal calculus. In a case on which I operated two years ago I was somewhat concerned to find that the patient passed no urine for twenty-four hours, and that the bladder was empty. I had previously ascertained that the other kidney was healthy, by the use of the ureteral catheter. Large injections of saline were given per rectum and the patient fortunately recovered.

Irritability of the Bladder.—Cases of bladder irritability are frequently brought to the surgeon to be treated for stone or other disease of the bladder, which, on cystoscopic examination, prove to be renal. In some cases stone in the kidney is found, but perhaps more frequently, some other affection, such as pyelitis, or tubercle of the kidney is discovered, so that it is not safe to diagnose cystitis or vesical stone from symptoms alone.

(To be concluded in our next.)

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Andrew Fullerton, M.D., F.R.C.S., Hon. Assistant Surgeon to the Royal Victoria Hospital, Belfast, and the Belfast Hospital for Sick Children. Subject: "Renal Calculus." Part 11.

#### ORIGINAL PAPERS.

# THE TREATMENT OF LABOUR IN CONTRACTED PELVIS. (a)

By Professor F. SCHAUTA, M.D.,

Honorary President of the Glasgow Obstetrical and Gynecological Society.

You have done me the honour of electing me Honorary President of the Gynæcological Society for 1907-1908. According to the rules of your Society, it is my duty to deliver before you an address during that time. Of the themes, the choice of which has been left to you, you have selected the subject "Labour in Contracted Pelvis." Thus, I appear before you to-night to speak in a country in which the science of contracted pelvis has been made classic.

Your great countryman, William Smellie, born in Lanark in 1697, must be considered as the real founder of the science of contracted pelvis. Obstetrics is indebted to him for the science of the mechanism of parturition, the first knowledge of the normal and pathological pelvis, and the measurement of the diagonal conjugate. He takes a firm stand against turning in contracted pelvis, as thereby the child is

(a) An Address delivered before the Glasgow Obstetrical and Gynmoological Society, April 7th, 1909,

too much endangered, and also against the application of foreeps above the brim. In order to restrain young practitioners from using the forceps in cases where the head is above the brim, thereby occasioning injuries to the mother, he recommends a short forceps, without pelvic curve, to be used only when the head had entered the pelvis. This view of discarding turning and the application of forceps above the brim is now again being revived by German obstetricians.

Regarding the rejection of the forceps, Smellie found powerful support in his countryman William Hunter. Indeed, Hunter went, in his views, beyond the standpoint of Smellie. The rejection of turning and forceps necessarily demanded the search for a substitute at a time when Cæsarean section was considered a deadly operation, and symphysiotomy, by reason of its great dangers, was then not even taken into account. Thus came into use the artificial induction of premature labour by Thomas Denmanm (1788) and craniotomy by William Osborn (1783). These eminent men had great confidence in the natural power of labour, a view strongly held to-day by all physicians.

Owing to Sir James Young Simpson, to whom we are indebted for the introduction of chloroform (1847), the long forceps and the cranioclast, turning in contracted pelvis was rehabilitated. This idea was based upon the assumption that the aftercoming head passes the pelvis more easily than the forthcoming head, contrary to the views of former physicians.

As the most distinguished exponent of the science

of contracted pelvis immediately after Smellie, George Stein the Younger, must be named. On the principles enumerated by these men, in conjunction with Michaelis and Litzman, our knowledge of labour in contracted pelvis has its foundation to the present day. The views held until recently regarding labour in contracted pelvis are in the main to be referred to the work of Smellie, Stein the Younger, Michaelis and Litzman. Their views are reproduced to-day in all text-books. Against these principles, firmly established for many decades and seemingly immutable, voices have been raised within recent times, maintaining that asepsis, which has made rapid strides, must be made use of more and more, in order to replace the old obstetrical for the so-called modern surgical operations, such as Cæsarean section and widening of the pelvis, and thus gradually paying a greater regard to the preservation of the life of the child, which, hitherto, was only taken into secondary consideration. This period seems to have begun more than twenty years ago with Kehrer and Sanger's improved method of uterine suture. But it was premature to substitute Cæsarean section, which was then and even now regarded as a most dangerous operation, for a method which allowed labour to take place through the natural passages. The reintroduction of widening of the pelvis, however, by the lateral incision has raised this question anew, which seems this time to be in a fair way of meeting with general acceptance. It appears to me, however, that even to-day the time has not arrived completely to abolish in contracted pelvis the so-called prophylactic opera-tions, such as artificial induction of premature labour, turning, craniotomy, and application of forceps above the brim, and to displace them by Cæsarean section and widening of the pelvis—operations which preserve the life of the child, although obstetricians of extreme views insist upon them at present. But all these questions have, no doubt, come within the province of practical discussion. And we are looking forward with joy to the time when it will be possible for us to discard all the interferences which jeopardise the life of the child, as we are living in an age which might be truly called the epoch of the child.

#### OPERATIONS IN CONTRACTED PELVIS.

The operations used in contracted pelvis are divided into three main groups. To the first group belong indicated measures, to the second prophylactic, and

to the third the so-called surgical operations. To the first-named groups belong all those measures which are indicated, not so much by contraction of the pelvis as by other anomalies of labour, anomalies which are mostly the result of contracted pelvis, but for the removal of which operative measures are absolutely necessary. These measures would be indicated apart from the complication of contracted pelvis. Among these operations must be named the application of forceps with the head in the pelvis, turning from a transverse presentation, the extraction by the breech, craniotomy on the dead child, and decapitation.

To the prophylactic operations belong artificial interruption of pregnancy (abortion or premature labour) and the so-called prophylactic version. The application of forceps above the brim is considered

by many to belong to this group.

To the so-called surgical operations belong all those in which the integrity of the mother's tissues is sacrificed in favour of the child, either by widening the pelvic space (symphysiotomy or hebotomy), or discarding the natural passages, by the formation of an artificial channel, whereby the child is extracted through the abdominal parietes and uterine wall (Cæsarean section).

Before we enter more fully upon the indications for the above-mentioned operations, we must discuss the question, which is very important, in relation to treatment, namely, how far we can count in cases of contracted pelvis upon spontaneous birth. This question has stood in the forefront of the discussion since Smellie's time, and has only been obscured from time to time by the overgrowth of operative methods which hindered the observation of the natural process of birth. With these operations, on the one hand the interests of the mother received too much consideration (abortion); on the other hand the interest of the child became more manifest (artificial induction of premature labour and prophylactic version)—operations which necessarily interfere with the observation of the natural course of labour.

Nevertheless, spontaneous birth affords by far the best solution of the many complicated problems of contracted pelvis. The objection might naturally be made that spontaneous birth is not always possible. This is, unfortunately, quite correct. But spontaneous birth is more frequently possible than it appears from our statistics. By premature inter-ference with its natural course, many cases of labour are directed into a wrong course and result in great injury to both mother and child.

At my clinique about 80 per cent. of the births with narrow pelvis actually occur spontaneously, in which only full term births are taken into account. is no doubt that if these principles, admitted in the present day, were universally and steadily observed, the number of spontaneous births in contracted

pelvis would steadily increase.

Now, the question forces itself upon us, does this expectant treatment not cause injury both to the mother and child-to the former on account of long duration of labour causing contusions to the soft parts, to the latter also from undue compression during birth? These consequences however do not occur These consequences, however, do not occur. Of all the possible methods of treatment of labour in contracted pelvis, the expectant treatment gives by far the best results for the mother as regards both mortality and morbidity. And I would mention here, that we consider the puerperium disturbed if the temperature has once risen to 38 deg. C. (100.4 deg. F.). Regarding the child we have also obtained the best results from spontaneous birth in preference to all other methods of treatment, with the exception of Cæsarean section.

We now come to the so-called indicated operations. Regarding results for mother and child obtained in cases of contracted pelvis by application of forceps when the head is in the pelvis, turning in cross presentations, craniotomy on the dead child, and de-capitation. One might be inclined to accept statistics without comment, as being those of patients treated

according to the prescribed and universally accepted rules, without there being any chance of deviation therefrom. Still, the question is justified, whether in all these cases a better result both for mother and child could not have been obtained by timely expert aid. In all the cases of turning the question is justified, whether another method of treatment could not have been adopted which would have been more advantageous to the child, thereby reducing the high mortality of the children. In a third of the cases where turning was resorted to, Cæsarean section or hebotomy carried out timeously might have saved these and probably other children. The same applies to breech presentation. In breech presentation, extraction need not always be adopted; a surgical operation may here, on account of the high degree of pelvic contraction, be quite as strongly indicated as it is in a cranial presentation. But these methods of dealing with such cases are partly of the past; nowadays an operation would certainly be considered.

Particularly must it be said regarding craniotomy on the dead child and decapitation that these operations have always been regarded as evidence of faulty midwifery. All these cases were admitted too late. Help was no longer possible for the child, and the mothers were, as the high mortality and morbidity show, frequently infected outside the institution. All these cases might have turned out differently if from the beginning a proper modern method of treat-ment had been adopted. I shall refer more fully to this point later on.

If we now turn to the more important group of prophylactic operations, the induction of artificial abortion must be put in the foreground. This operation was introduced by William Cooper in 1771, in order to avoid Cæsarean section where it was absolutely indicated. Cohnstein in 1874 could collect only ten cases, in all the literature, in which it was carried out in extreme contraction of the pelvis. To-day this operation has lost its justification on account of the safety of Cæsarean section. For this indication I have never operated.

On the contrary, the induction of artificial premature labour must be considered a justifiable and thoroughly established operation in contracted pelvis. It must be considered along with prophylactic turning, in the forefront, as a method in favour of the child, in order to avoid craniotomy at the normal term.

The indication given for induction of artificial premature labour is a conjugate between 7½ cm. and 82 cm. in generally contracted pelvis, and between 8 cm. and 9 cm. in flat pelvis. But when one can count on spontaneous birth in a conjugate of 8 cm. and even of 71 cm., the indication for induction of artificial premature labour falls to the ground on this score.

Nor is artificial induction of premature labour the easy method which some authors consider it to be. If only the operation in its narrowest sense be considered, such as the introduction of a bougie, artificial rupture of the membranes, or the plugging of the cervix, then certainly would the operation be a simple one. In the further progress of the case, however, other and more serious operations will have to be considered, which one cannot say would have been unavoidable had one waited for the normal termination of labour.

All cases of premature labour do not terminate spontaneously. One does not get a clear picture of the significance of artificial induction of premature labour if only the cases are counted in which spontaneous birth occurs. The high mortality of the children has rightly matured the question, whether one is justified in regarding the operation of artificial induction of premature labour as an operation carried out solely in the interest of the child. The result of births in the same woman, both mature and premature, were brought forward as an argument in favour of this operation. It was Dohrn who first put this view forward. But many of the births enumerated belonged to a former period of time and were not conducted under clinical treatment. Circumstances may have occurred which might have easily

operated unfavourably to the children.

The following observation appears more profitable:

—If we take from our total number of cases of contracted pelvis those which according to general opinion appeared particularly adapted for the artificial induction of premature labour, for example, multi-paræ with a conjugate from 7½ cm. to 8½ cm., and if we likewise eliminate artificial induction of pre-mature labour from the methods of treatment, we find that the very cases in which artificial induc-tion of premature labour has been discarded have had a more favourable result for both mother and child.

If, in opposition to some authorities, we are not inclined at the present moment to abolish the induction of premature labour from our list of operations in contracted pelvis, we would, at least, still further limit that operation to cases of multiparæ who are known to have given birth to large children with well-developed heads, children who are capable, in spite of their prematurity, of holding their own with weak and badly-developed, though mature, children. Such children, however, can only be regarded as premature in respect to the duration of their intrauterine life, and not in respect to the degree of their development. From a social point of view, it cannot be our task to put into this world premature and weakly children. In the struggle for existence, we require strong and well developed individuals.

Prophylactic turning as regards my clinique must be looked upon as a rare operation. If we would estimate the value of prophylactic turning in contracted pelvis, we must, as we have done in discussing premature labour, take into consideration the total results—first inclusive, then exclusive of prophylactic turning; more especially must we do this in that category of cases in which one expects from prophylactic turning the best result, namely, multiparæ with flat pelvis and a conjugate between 8½ and 9½ cm. The foregoing comparison, however, shows that the total result of prophylactic turning is unfavourable, and especially in those cases which are most suited for that operation, contrary to all reasonable expectation.

Very instructive, finally, is the comparison between spontaneous birth and prophylactic turning in respect of their results in the same categories of contracted pelvis, a comparison in which the circumstances most favourable for prophylactic turning have been assumed. In these cases, likewise the results of prophylactic turning are unfavourable. From these statements it is clear that in cases where there is a probability of spontaneous birth, prophylactic turning should be discarded.

The application of forceps above the brim, considered by some authors as belonging to the prophylactic measures, should not be included in this group, since it is used only in an advanced stage of labour with certain indications. Its use is justified as a last attempt to save the child, in cases where craniotomy on the living child might be considered neces-

If we consider the cases in which, in the absence of urgency regarding the mother, the operation has been performed solely in the interest of the child, we obtain an infantile mortality of 50 per cent. An operation which can by no means be regarded as free from risk to the mother, and which, when undertaken solely in the interest of the child, affords the saving only of every second child, should surely be replaced by another. Only when the operation is undertaken in cases of minor degree of contracted pelvis—between 8½ and 10 cm.—cases in which there is urgency on the part of the mother, can the application of forceps be tried, to be immediately replaced by craniotomy,

if any difficulty be met with.

In connection with the operation of prophylactic turning and the application of forceps above the brim, mention also should be made of craniotomy on the living child. This operation should, according to the view of some obstetricians, e.g., Pinard, be

entirely discarded. We cannot, however, altogether dispense with it to-day, as we regard it as an operation of necessity in cases where we find it impossible to carry out any of the alternative operations. In the future, Cæsarean section or hebotomy will take its place. To-day it is still indispensable in cases which reach expert aid too late, or in advanced stages of labour, often febrile from infection, where Cæsarean section or hebotomy is contraindicated, and in which, on account of the head being high above the brim, forceps cannot be applied, or on account of high degree of contraction of the pelvis, turning could not be performed and where the completion of labour is urgent.

It is, therefore, in the true sense of the word, an operation of necessity.

Craniotomy on the living child is one of the operations which will in the future be entirely eliminated from the list of obstetrical operations. We shall see at the end when and under what circumstances we may expect this golden age in obstetrics. In the meantime this operation should be limited as much as possible.

CÆSAREAN SECTION.

When we finally enter into the discussion of the so-called surgical operations in contracted pelvis, Cæsarean section, where absolutely indicated, might be put in the first place. The morbidity during the puerperal stage as shown by the mortality amounted to 17.2 per cent. These results should show a material improvement in the near future by the improved method in the protection of the wound, as it is customary in laparotomy at my clinique (rubber gloves, wound mask, and painting the abdom.nal walls with iodine).

The method of performing Cæsarean section at my clinique is by means of the usual longitudinal section of the uterus. The transverse section is only used in cases where there is considerable stretching of the lower segment of the uterus. As sutures for the uterine wound, silk is used in two layers.

The latest and most recent of obstetrical operations in contracted pelvis is that of hebosteotomy. We prefer it to symphysiotomy, on account of its more lasting results It is indicated in a contracted pelvis of 71 cm. to 81 cm. conjugata vera, when there is no infection, and the mother does not absolutely object to the operation.

For the operation of hebosteotomy the same stringent indications are not required as for Cæsarean section.

Patients who have previously been examined may undergo the operation of hebosteotomy, provided they show no signs of infection at the time of the operation, while for Cæsarean section absolute asepsis is a sine qua non. I would not like to go the length of some surgeons, who do not see in manifest infection a contra-indication to hebosteotomy. We operate in the manner of Döderlein by the subcutaneous method of incision, and await spontaneous birth, unless there is urgency to complete labour. All the cases, even those in which symphysiotomy had been previously performed (total, 23 cases) were successful. In 73.4 per cent. of the cases there was, however, some fever during the puerperium, due to the not infrequent during the puerperium, due to the not innequality injury to the soft parts. Only one of the children died (4.3 per cent. infantile mortality).

Accordingly it is essential that better results should in the near future be obtained in hebostcotomy with

respect to its high morbidity. This improvement will occur if we make it a principle to wait, particularly in primiparæ, for spontaneous birth. This method has been practised at my clinique only since the middle

of 1907,
Finally, if I am permitted to review the experience hitherto gained regarding the treatment of labour in contracted pelvis, and to draw conclusions therefrom, for the future, I might express myself as follows :-

The management of labour in contracted pelvis will shape itself in the future in the following simple manner, provided it is carried out from the very commencement in a skilful manner and in an institution under strict asepsis. In cases with a conjugate above 8 cm. there is a possibility of spontaneous birth, and therefore expectant treatment is to be adopted. In cases under 8 cm. Cæserean section is to be kept in view. In cases bordering on the above, i.e., a conjugate of 8½ cm. to 7½ cm., hebosteotomy is to be considered. This operation in a conjugate, of 8 cm. to 8½ cm., would be an alternative operation to spontaneous birth; in a conjugate of 7½ cm. to 8½ cm., an alternative to Cæsarean section. The choice would be determined by the size and hardness of head, the strength of labour pains, the voluntary efforts and general condition of the patient. This method of treatment should be looked upon in the future as typical.

All other methods hitherto used in the treatment of labour in contracted pelvis should be looked upon as non-typical. They are not to be considered as methods which were brought into use on account of the difficulty a contracted pelvis created in labour, but as entirely foreign to the subject, and they should not be capable of replacing the typical operations.

not be capable of replacing the typical operations. Craniotomy on the dead child, therefore, may be indicated in a conjugate under 9½ cm. The death of the child justifies in this case the adoption of a non-typical method of treatment. Craniotomy on the living child may become necessary if the mother is in a state of infection and refuses to undergo any of the typical operations. Artificial induction of premature labour may also have to be performed in cases in which the mother is suffering from illness and Cæsarean section or hebosteotomy at the normal term would be too dangerous, or where it is positively known that the children are abnormally large, or the mother absolutely refuses an operation. The application of forceps above the brim and prophylactic turning should, if possible, be entirely deleted from the list of methods of treatment in contracted pelvis.

The application of forceps above the brim might exceptionally be tried before craniotomy on the living child is resorted to, and it will probably be possible occasionally to save a child. Before craniotomy on the living child is undertaken, prophylactic turning may be justified in certain degrees of contraction in a simply flat pelvis, when Cæsarean section or hebosteotomy, on account of illness of the mother, is out of the question, and a trial with the forceps affords little hope of success on account of the high position and mobility of the head. The two last-mentioned operations (forceps above the brim and prophylactic turning) will find their indication in such atypical cases as a last attempt to save the life of the child before craniotomy is resorted to-forceps when the head is fixed, turning when it is movable. That the so-called indicated operations have at times to give place to surgical operations, as shown by our discussion, I have already previously mentioned.

In a conjugate under 61 cm., Cæsarean section is

In a conjugate under 6} cm., Cæsarean section is absolutely indicated, if the case be aseptic, with suture of the uterus; if septic, with total extirpation or supra-vaginal hysterectomy, even the most recent investigation into the management of labour in contracted pelvis will not alter this fact, and I therefore do not enter further into the question.

On the whole, our aim should be to leave labour in contracted pelvis as long as possible to the natural forces, and failing them, to perform only those operations which will most likely save both mother and child. All other operations should gradually be more and more limited. Until this golden age of the treatment of labour in contracted pelvis appears, there are certain conditions to be fulfilled.

The patient must reach the expert in an absolutely aseptic condition without any obstetrical interference of any kind having been made. The circumstances should be such that every kind of obstetrical operation can be immediately undertaken strictly aseptically; finally, our hands should not be tied from carrying out a certain operation by the refusal of the patient or her relatives.

All these conditions may most certainly be fulfilled in the case of patients with a high degree of pelvic contraction, especially if they have had difficulty with previous births, who seek admission to an institution from the very commencement of labour. In this way only can initial asepsis be assured and all the inopportune attempts on the part of the midwife and practitioner be eliminated, which so often lead to failure.

The natural forces will be more effective than when the patient, the relatives, and the midwife influence the doctor in attendance by demanding a rapid delivery of the case. If an operation becomes necessary, everything is at hand and no time is lost by taking the patient to an institution, where, as usual, after a lengthy consultation, a surgical operation is put aside in favour of another, which certainly could have been carried out at home, but which is only in the interest of the mother and to the detriment of the child. Thus I come to the last point, namely, the question of refusal on the part of the patient to undergo a certain operation.

There is no doubt that we must not perform an operation, whether obstetrical, gynæcological, or surgical, without the consent of the patient. Assuming this general consent, the choice of the operation should be left in all its details to the operator. In gynæcological operations this has been customary for a long time. Why, then, should the patient have the right to refuse a particular operation which the operator in the case, after mature deliberation, considers to be the best for both mother and child. It is the request for consent to perform a specially named operation which suggests to the patient that this operation is particularly dangerous. Still we perform other dangerous operations without the special consent of the patient. Application of forceps above the brim and prophylactic turning have also their dangers. In these operations injuries also occur, such as lacerations and wounds, to which the straight aseptic incision is preferable. Still nobody asks the patient if she would allow any of these operations or the destruction of her child by craniotomy. Let us, however, frankly admit that, with regard to surgical operations in contracted pelvis, we still stick to the traditions of the time when Cæsarean section was a deadly operation, but it is high time we should break with these traditions.

It is certainly quite true that Cæsarean section, and to some extent, also, hebosteotomy, are even to-day more dangerous than all the other, obstetrical operations in contracted pelvis. If, however, a patient, in whom such an operation may become necessary, would from the very beginning get into a public or private institution, where everything can be carried out strictly aseptically, to await her confinement there, then all these influences which affect Cæsarean section so adversely would disappear. Nowadays patients seek admission to an institution at all times, night and day, often in a badly neglected condition. In the space of half an hour everything is to be made ready for Cæsarean section, the abdominal walls are to be disinfected, an anæsthetic to be administered, although the patient may have shortly before partaken of food and drink. The sur-geons of the institution, who are not prepared for laparotomy in the late hours of the evening or night, must hurriedly disinfect themselves, which is very often inadequately done, as their hands in the course of the preceding day's work have become infected. That in such circumstances infections and pneumonias occur our statistics show, as do those of other cliniques. Upon these statistics, however, I base my opinion regarding the danger of Cæsarean section. statistics must be collected anew, with the elimination of all the incidents I mentioned above. All the dangers of this operation will then be reduced to a minimum, and everyone of us will be able to undertake with a clear conscience every kind of obstetrical operation. Until then, however, by a careful selection of cases, the percentage of danger should be reduced to the lowest minimum.

I regard as intolerable and a hindrance to all future progress the constantly recurring statement that the country practitioner cannot and should not perform Cæsarean section or hebosteotomy, and should, therefore, as formerly perform only the prophylactic opera-tions and high forceps operation. For this reason all obstetrical schools lay great stress to this day upon the teaching of these operations. If the general practitioner, however, would get accustomed to recognise timeously high degrees of contracted pelvis, i.e., before the onset of labour, and to assign all these cases, also timeously, to obstetrical institutions, then might progress also be made in the country and in

private practice.

Physicians must be taught to think and to make their influence felt upon midwives and on the public generally, and not to stand, as hitherto, inactively awaiting events, and ultimately performing an oldfashioned operation, most frequently forceps and craniotomy, whereby the child is sacrificed. Innumerable cases in my own experience have proved to me that it is possible to instruct physicians in the way I have mentioned, and not permit them to adopt

a fatalist attitude towards events.

The level of education of midwives should be raised

pari passu with that of the physicians.

We gain nothing by the statement that the physician is mostly called too late. We must strive to change all this, and it will be changed if we try our utmost in that direction. Obstetrical schools in this respect should take the lead, and not, as often happens, completely resign themselves to fate. General practitioners must endeavour to bring the level of their knowledge to that of clinical specialists, and should not seem, as frequently appears to-day, as though they were adopting the opposite course.

I am at the end of my long address. It is difficult however, to shorten such an important chapter of Almost all obstetrical operations must be mentioned and discussed in their past and future bearing upon our subject. If, perhaps, it appears that my proposals go too far, still the higher the aim the more we will attain. Our fate, however, will be to remain somewhat below the highest standard, for we are human and have to deal with humanity, whose human arrangements and prejudices we have to combat. If I have succeeded in gaining the co-operation of the physicians of Scotland, who have always stood in the forefront of obstetrical science, in reaching this high goal, I would feel that my time and labour have

#### A CASE OF PRIMARY CARCINOMA OF THE VAGINA. (a)

been amply rewarded.

By GORDON W. FITZGERALD, M.D. Ed., M.CH.,

Examiner in Midwifery and Gynsecology, Durham University College of Medicine, Newcastle-upon-Tyne; Lecturer in Midwifery, Manchester Union Hospital.

THE rarity of malignant disease having for its primary focus the vagina is my chief reason for bringing this case before the Society. Though cases of this kind are usually shown or described at one of the medical societies, or reported in one of the medical periodicals, the search for recorded cases is a most tedious undertaking, and the sum of one's investigations of the literature is only a few score of cases.

The patient, æt. 26, had at the time of my seeing her been married eight months, and had never been pregnant. I saw her on December 2nd, 1908, and the history she gave was that for eighteen months she had been troubled with an offensive vaginal discharge which had latterly been blood-stained. On November 26th her expected menstruation came on, and the amount was so much in excess of the usual that she consulted Dr. Gregory, with whom I saw her. She had at

no time experienced any pelvic pain. She thought that she had grown somewhat thinner, but was a plump young woman and looked in the best of health.

On vaginal examination the cervix could be felt in its normal position and of normal consistency, and the uterus not enlarged, normally situated, and fairly movable. The left fornix could be felt to be the site of an irregularly punched-out depression, which on inspection was found to be an ulcerating area about the size of a two-shilling piece, of more or less circular shape, with in-It was durated, clean-cut and everted edges. about a quarter of an inch in depth and its base showed raised spots of a bright red and angry appearance, with here and there little sloughing areas. The odour of the discharge was rather that of a sloughing polypus than that of malignant disease.

The vicer came very close to the uterus, but a small band of healthy and non-indurated tissue separated it from the cervix, while the latter-the cervix—appeared to be healthy. No enlarged

glands were found in either groin.

On December 5th I removed a portion from the edge near the cervix and another from the edge bordering on the left vaginal wall. These specimens Professor Delépine kindly examined microscopically for me, and declared them to be typical specimens of squamous-celled carcinoma-and he is of opinion that the condition is a primary

vaginal growth.

The operation—which was done on December 8th -I started with the hope that it would be possible to save the uterus, and, with this object in view, divided the anterior, left lateral and posterior walls of the vagina well clear of the growth and the surrounding induration, and completed the incision by cutting into the left side of the cervix. The vaginal walls were then dissected up and an endeavour made to free the ulcer from its base. In this I was not readily successful, as it was very closely adherent to the bladder and the uterus. This very close relationship with the uterus decided me to remove that organ, for it seemed highly likely that, though no evidence of involvement of the uterus had as yet been discovered, the pro-bability of its being already the seat of malignant disease was very great, and hysterectomy, therefore, seemed almost imperative. The operation was completed by the abdomen. This route gave me much greater freedom in dealing with the adhesion to the bladder, and enabled me to search the pelvis for infected glands in a manner which would have been impossible had the operation been completed by the vagina.

Despite this extra freedom, it was only with a great deal of difficulty that the bladder was liberated. Having removed the uterus, I cleared out as carefully as possible the left appendages and the cellular tissue on the left side of the pelvis, making at the same time a search for infected glands. No enlarged glands were found at all.

Before closing the abdomen the bladder was examined and a catheter passed; the urine drawn off was clear and no evidence of wounding was found. I mention this for the reason that on the day after the operation, and again the day after that, she passed urine which contained quite a large amount of blood. On the fourth or fifth day of her convalescence the blood disappeared and was not again seen. The hæmaturia, I take it, was evidence of the fact that though the bladder showed no evidence of wounding, there must have been some-she never had passed blood beforeand it naturally raises the question as to whether

<sup>(</sup>a) Paper read before the North of England Obstetrical and ynmeological Society, at Liverpool, Feb. 19th, 1909.

the bladder was not to some extent already involved. She made a very good convalescence, and went home in three weeks.

It is interesting to look to the recorded experiences of others in an endeavour to form some idea as to the frequency with which carcinoma is found as a primary condition in the vagina, its disposition, and the results of operation.

Both sarcoma and carcinoma are found affecting primarily the vagina, and, while the former is admitted by all authorities to be of extreme rarity, carcinoma is regarded as being of sufficient rarity to render the records of a case always of interest

and value.

Its frequency is varyingly estimated. Williams (London Hospital) says it occurs in 0.43 per cent. of all cases. Hart and Barbour collected fourteen cases out of a total of 8,287 cases of cancer of the female generative organs-a percentage, roughly, of 0.17; Christian Fenger collected fifty-seven cases out of all the literature on the subject, while, at a somewhat earlier date, Kustner and Preuschen together collected thirty-three. These are included in Fenger's series. On looking through the "Transactions," I find that only one case has been brought before this Society-the specimen was shown by Dr. Gemmel at the November meeting last year; in the "Transactions of the London Obstetrical Society" I find one case reported by Dr. F. J. McCann, while in the "Transactions of the Gynæcological Society," and more recently in the state of the Parel Society of Medicine I find those of the Royal Society of Medicine, I find none, and, except as a reference to the proceedings of one or other society, there is no record of such a case to be found in the Journal of Obstetrics and Gynæcology of the British Empire.

From this scarcity of cases, and the small percentage quoted by one or two, one naturally concludes that the condition is an uncommon one, but I think we must accept as highly probable the fact that a great many more of these cases occur than one can find records of; they are either not recognised as such or are not recorded. Dr. James Oliver has published the records of three cases, the youngest being the same age as my own case—26. In this patient there had been pain for eight months, and profuse watery and offensive discharge for only four months, following on twelve months amennorrhoea after confinement. The whole of

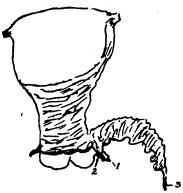
the vagina was in a cancerous state.

In his two other cases, the ages of whom were 62 and 53 respectively, they were very far advanced also, and there was marked involvement of the inguinal glands; no mention is made of this in the first case; pain was absent in both of these cases. In two out of three there is recorded an involvement of the inguinal glands, but in view of the fact that the condition was so far advanced, this is not surprising. Indeed, though the majority seem to regard the condition as less prone to lead to involvement of the glands in the groin than is the case with uterine cancer, the stage of the disease and the position in the vagina must be the most potent factor in deciding this, in virtue of the distribution of the lymphatics in the vagina. There appears to be a generally-entertained opinion that carcinoma occurs earlier as a primary growth in the vagina than it does in the uterus. According to Fenger it may roughly be said to occur ten years sooner in the vagina.

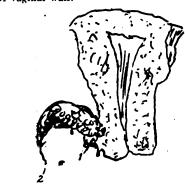
Howard Kelly and Noble, in the brief reference which they give to this important condition, say that it usually occurs after the fortieth year, but that it has been found in children. I have been unable to find any record of the condition occurring

in children; indeed, the youngest patient is one who was under the care of Mr. C. Arthur Wood in the Nagasaki Hospital, Japan; her age was 22.

Site.—With but few exceptions the posterior wall of the vagina is the site of the growth. In twenty-five out of twenty-nine cases Fenger found it so situated, two being on the anterior and two on the lateral walls. Butlin, who has given attention to this subject in his "Operative Surgery of Malignant Disease," is also strongly of opinion that the posterior wall is the most usual site. This case I am now recording is the first case of the kind I am now recording is the first case of the kind I show very clearly the position of the growth to be lateral. It is seen still occupying its original



Anterior surface of uterus with ulcer attached. 1. Edge of ulcer. 2. Apparently healthy tissue. 3. Tag of vaginal wall.



Anterior half of longitudinally bisected uterus. 1. Growth encroaching on cervix. 2. Tag of vaginal wall.

position in relation to the uterus. Its very close attachment to the cervix, which already has become involved to some extent, and the numerous and dense adhesions to the bladder, suggest that the next and by no means remote stage would have been the more or less extensive involvement of these. As a rule the bladder, rectum and uterus appear to be attacked quite early in the course of the disease; in some of the reported cases the distress experienced in consequence of this appears to have been the primary reason of advice having been sought. In my own case, however, the offensive discharge had persisted for eighteen months, and it is therefore hardly an example of the condition spreading very rapidly, vet the pathologist is of the opinion that it shows indications of rapid growth. The condition is described as assuming one of two forms, either the ulcerating-of which my own case is an example—or a diffuse infiltra-tion of the walls. When primary in the vagina

the carcinoma is practically always of the squamous-celled-the epitheliomatous variety. The infiltration may go on to the stage of practically complete occlusion of the canal, one of Dr. Oliver's cases being an example of this; and it is distinctly

the more rapidly spreading form.

We so seldom see these cases at a sufficiently early stage that, though one recognises that operation should be done very early in the history of the case to hold out any hope of cure, the results so far got from operation are by no means as good as one would hope for them to be; 80 per cent. to 90 per cent. of cases operated upon have recurrence of the disease. Patients will frequently tell us that the condition has persisted for only two or three months, but I am sure I am not wrong in saying that it is most exceptional for us to see a patient with malignant disease in so early There can be no doubt, too, that a patient will frequently be allowed to go on with a malignant growth until she arrives at almost the stage of its being inoperable in consequence of no vaginal examination having been made in the first instance-for this the patient is often quite as much, if not more, to blame than the medical attendant.

Recurrence seems in most cases to have been very rapid. No doubt the absence of glandular involvement should lead one to be more hopeful.
Of all the operations for the removal of the growth Olshausen has suggested the most radical.

I saw my patient on January 26th. looking very well and declared that she had gained weight; the local conditions, too, I found on examination to be quite satisfactory.

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#### A NOTE ON OXALATE OF CERIUM.

By J. C. McWALTER, M.A., F.F.P. and S. Glas., M.D. Brux.,

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OPERATIONS for gastric ulcer now occupy much of the attention of surgeons, and so many of them harangue the poor practitioner on the necessity for early diagnosis and immediate operative procedure that one is almost afraid to suggest the futility of most of these undertakings. At least it is the experience of many physicians that some 90 per cent. of those cases clinically diagnosed as gastric ulcer get almost well with the bismuth and morphine treatment—whilst probably 50 per cent. of cases treated by operation are worse after a couple of years.

In connection with the medical treatment of ulcer of the stomach, hyperchlorhydria, hunger pain or allied conditions, I wish to draw the more earnest attention of the profession to an old but neglected remedy-oxalate of cerium. All the world knows that in the vomiting of pregnancy it is almost a specific—thanks to the enthusiastic praise of Simpson-but in inflammatory or erosive conditions of the intestinal mucous membrane it appears to be not only of considerable service, but in many respects better than bismuth.

Since radium became the rage in scientific circles, much attention has been devoted to the rarer metals. Cerium is found as a by-product in the preparation of thorium from monazite, and as found in commerce, consists of cerium, lanthanam and didymium oxalates.

Cerium nitrate is largely used in the preparation of incandescent gas mantles, and is a salt soluble in water, and convenient to administer in the effervescing form, but clinically, the better preparation is probably the insoluble oxalate, because cerium is not absorbed, but acts locally and

mechanically like bismuth.

The oxalate of cerium depends for its therapeutic properties not only on the base, but in the acid radicle. To the modern mind oxalic acid is nothing but an irritant poison; but Neligan long ago pointed out that minute doses of oxalic acid-I to 3 grains—were invaluable in inflammatory conditions of the gastric mucous membrane. Its action is on the nervous element of gastric disorders, and modern writers have shown that the pain which accompanies gastric erosion or ulceration is due rather to the spasm which succeeds the ingestion of food than to the local effects of the gastric secretion on the raw surface of the membrane.

Oxalate of cerium is best given, not in pill, but in powder or mixture. It is best of all combined with bismuth—say two grains of cerium to ten of bismuth. It appears to do excellently in the ordinary bismuth mixture of the hospitals as an addition of some thirty grains to each dozen doses. The constipation which usually accompanies the taking of bismuth soon lessens by its use, and the lack of desire for food, which is another concomitant, becomes almost absent.

Some may sneer at such insistence on the properties of a drug whose action is largely mechanical, but gastric ulcer is one of the commonest diseases, and one of the most painful and fatal. Its treatment is practically either by operation, rest, or bismuth and morphine. there be a further remedy in oxalate of cerium it is well to spread its fame.

#### OPERATING THEATRES.

GUY'S HOSPITAL.

CASE OF RUPTURED URETER DUE TO TRIVIAL INJURY.—MR. R. P. ROWLANDS operated on a youth, set. 18, who had been admitted complaining of great pain in the left side of the abdomen. Two days before admission, whilst walking along the pavement with his left hand in his pocket, he fell on his left elbow, his hand being driven against the lower part of the abdomen, and causing an agonising pain shooting up to the left loin. Gradually a swelling appeared on the left side of the abdomen, and the patient was sick several times. On admission the temperature was 102°, and pulse 110 to 120. The lower part of the

abdomen moved but little on respiration; the left iliac fossa was fulle: and less resonant than natural, and very tender. If the local signs had been on the right side, his general and local condition would have agreed well with an attack of appendicitis. There was some tenderness and fulness in the left loin pos-The bowels were constipated, the urine and teriorly. The bowels were constipated, the urine and the act of micturition were normal. The viscera were not transposed.

The abdomen was explored through the lower part of the left rectus. Some clear fluid escaped, but there was no septic peritonitis, and the appendix was normal. The retro-peritoneal tissue and the left mesocolon were very &dematous, with a greenish translucent appearance. The swelling extended up to the left kidney, which appeared to be normal in size and consistency. The abdomen was closed, and the patient was turned over on to his right side, and the left kidney was explored. On opening the peri-renal tissue a good deal of slightly blood-stained fluid escaped. With some difficulty the kidney and the upper part of the ureter were isolated, and a clot of blood was seen plugging a large rent at the junction of the ureter and the renal pelvis inferiorly. The laceration extended nearly all the way round, a small part still remaining undivided at the upper and inner part of the tube. The clot had obstructed the lumen of the the tube. The clot had obstructed the lumen of the ureter. The rent was sutured with fine catgut in such ureter the lumen of the ureter ureter. The rent was sutured with fine catgut in such a way that no narrowing of the lumen of the ureter resulted. This was not easy because of the depth of the wound, and the great amount of cedema of the surrounding tissues which kept flapping into the way The loin was drained by means of a large cigarette drain, and the wound closed all round.

Mr. Rowlands said that, although a ruptured ureter was suspected, the accident seemed to have been too trivial to produce such a severe injury, but, in the light of after events it seemed clear that the left hand impacted upon the ureter and pressed it inwards upon the pelvic brim, thus tearing the tube from the more or less fixed kidney. The situation of the rent at the lower and outer part of the junction of the renal pelvis and the ureter confirmed this view. The absence of hæmaturia and of all urinary symptoms, and the signs suggestive of local peritonitis in the left iliac fossa, added difficulties to the diagnosis and rendered an abdominal exploration necessary. A cystoscopic examination might have made this unnecessary, but no harm was done and but little delay caused by the preliminary exploration, which at ouce settled the diagnosis. The prospect of complete recovery of the kidney after suture of such an extensive laceration seemed poor at first, Mr. Rowlands thought, but the difficulties would probably yield to the careful plastic

operation he had just performed. The absence of hæmaturia, he pointed out, was not uncommon in case of complete or nearly complete rupture of the ureter, and the accident is often unexpected until a swelling appears in the loin.

At first nearly all the urine escaped through the

loin, and it was feared that another operation would become necessary; but after about ten days a little pus appeared in the urine, and the amount passed per methram gradually increased. The sinus in the loin closed at the end of four weeks. The patient was seen quite well two and a-half months after the operation, and he has returned to his work, the urine being

normal and the youth having gained considerably in weight.

#### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD FRIDAY, MARCH 26TH, 1909.

Dr. EDMUND CAUTLEY in the Chair.

EXHIBITION OF CASES AND SPECIMENS. MR. MACLEOD YEARSLEY showed a case of a peculiar form of word-deafness successfully treated by the oral

method. The child could not appreciate heard speech, which she merely repeated aloud, but when she was which she increased repeated about the word-able to see the speaker such seen speech (lip reading) was immediately answered rationally. The wordwas immediately answered rationally. The word-deafness apparently prevented the higner centre being effective, but she has now learnt to understand by lip reading. After practice, with great effort heard phrases are now understood and answered without the motor response of repeating the question. Mr. Yearsley thought that it was difficult to explain the case on any hypothesis other than that of weakness of the auditory centres.

Dr. H. C. MANN exhibited a specimen of a tumour (7 in. long by 4½ in. broad), of the left suprarenal obtained from the body of a child, æt. 2. The kidney lay at its lower pole. The growth extended through the diaphragm, invading the pericardium and left lung. The left pleura contained nearly a pint of blood-stained fluid, and showed small secondary growths. The cervical glands were sarcomatous. Secondary deposits were also found in the orbital plates, in the right parietal bone, and in the sternum. The child came to hospital with a history of 6 weeks' weakness and anæmia. A leucocyte count showed 15,000 white cells; hæmoglobin and red cells, 60 per cent. The tumour, which during life was apparently splenic, enlarged rapidly under observation. It moved well with respiration. Death occurred two months later. The tumour was a round-celled sarcoma.

Dr. EDMUND CAUTLEY showed (1) the brain from a case of cerebral diplegic spasticity, which had been shown to the section on February 20th, 1909. The whole of the frontal and parietal regions was converted into a bilateral cystic form, bounded mesially by a wall containing a moderate amount of brain substance. According to the history, the child had been healthy till the age of 7 weeks, and then had an illness which could be accounted for as encephalitis or menin-The post-mortem appearance made it more probable that the condition was congenital, dependent on developmental error in the prosencephalon. (2) A specimen of congenital heart disease, showing transposition of the aorta and pulmonary artery. The right ventricle was the larger, and gave off a normal aorta from which the great vessels arose by a common origin. The left ventricle gave off the pulmonary artery, which was stenosed on account of two of its valves being adherent. There was a small opening in the interventricular septum, and the foramen ovale was patent. The ductus arteriosus was normal. The child lived till. 11 months, showing moderate cyanosis and clubbing. The heart was enlarged to the right of the sternum. There was a systolic pulmonary murmur, and a systolic

murmur heard at the apex and behind.

Dr. LANGMEAD said that there was a specimen in. the museum of Great Ormond Street Hospital which closely resembled Dr. Cautley's first case. It showed some narrowing of the small cerebral vessels.

Dr. G. CARPENTER said he had neither seen nor read of a case like Dr. Cautley's, but had seen a locular cystic condition, which Dr. Ernest Jones reported was, in his opinion, syphilitic. During life the child had been spastic, with head retraction, and showed atrophic patches in its choroid.

Dr. JEX-BLAKE showed a female child, æt. 7, with congenital heart disease. She had a good colour, and weighed 28 lb. Over the pulmonary area a continuous murmur could be heard, loudest during systole. It could also be heard over the whole chest, back and

Dr. Whipham thought there were one or two small glands to be felt in the neck. If the murmur was not due to glands, he would agree that it was caused by a patent ductus arteriosus.

Dr. G. LE B. TURTLE asked whether the murmur varied in intensity from time to time. when it was due to enlarged glands.

The CHAIRMAN thought that it was a purely systolic murmur, and was inclined to ascribe it to some pulmonary stenosis and patency of the inter-ventricular septum, than some other defect, because there was so much hypertrophy. The child had not grown well, which he thought meant a bad prognosis.

Dr. JEX-BLAKE replied that the murmur had not

been noticed to grow louder or softer at different times. Dr. G. CARPENTER exhibited a case of congenital malformation of the heart, showing a patent ductus arteriosus, with bicuspid aortic valves. The child died arteriosus, with bicuspid aortic valves. The child died at the age of three months. During life there was a systolic murmur, best heard over the third left space just inside the nipple line conducted towards the left clavicle. The left side of the heart was the larger. The right ventricle was dwarfed. The foramen ovale was closed.

Dr. WHIPHAM gave a pathological report upon 'he specimen of congenital cystic disease of the kidneys, shown at the Section on January 22nd, 1909. The sections showed small cysts, with a great increase of connective tissue. The tubules were mostly dilated, but many were contracted. Glomeruli were somewhat contracted, but Bowman's capsules were dilated. The arteries were thickened. The pancreas showed some fibrosis and thickening of its vessels. The bile-ducts of the liver were dilated and convoluted. The spleen showed an excess of connective tissue.

Dr. PARKES WEBER thought that the spaces in the portal fissures might be blind spaces, and not dilated bile vessels. In that case the liver was an example of

cystic liver.

Dr. T. R. WHIPHAM showed transparencies and photographs of a case of bullous purpura following impetigo in a boy, æt. 4. There was no history of hæmophilia or of syphilis in the patient or his family. The fluid from the bullæ contained degenerated bloodcorpuscles, but no growth of organisms could be obtained by cultivation. From the impetigo lesions a mixed growth of staphylococcus albus, citreus and streptococcus was obtained. The patient was given boracic baths, and the bullæ either were punctured or burst spontaneously, leaving deep, sloughing ulcers. Under treatment with hydrogen peroxide, chinosol baths, and balsam of Peru dressings, the ulcers cleaned, and the condition was now cured.

Dr. G. Pernet referred to a paper he had read on bullous impetigo contagiosus in children who had pediculosis. The purpuric condition was more unusual. He thought, in the present case, that the purpura was

of streptococcal origin.

Dr. Whipham showed a case of transposition of the viscera in a girl, æt. 8. There was a mitral systolic murmur at the heart's apex. The child had had chorea twice.

The CHAIRMAN thought that such cases were not so uncommon as one was led to believe in books. He believed that prognosis of life was just as good as if the heart were not transposed.

Dr. F. J. POYNTON and Dr. LANGMEAD thought that

if the heart was on the right side of the body, there

was greater liability to endocarditis.

Dr. PARKES WEBER asked whether proposers for life assurance should be rated up if the viscera were transposed?

Dr. Whipham thought not.
Mr. O. L. Addison showed (1) a case of ankylosis of both hip-joints ascribed to scarlet fever, and (2) a case of syphilitic osteoperiostitis.

The CHARRMAN asked what treatment had been adopted in Case 2, and Dr. E. I. SPRIGGS asked whether the tissues or fluids had been examined for the spirochæte.

Mr. Addison replied that after operation the general conditions had improved under mercury and iodide. There was still a sinus over the tibia. Spirochætes had not been looked for.

Dr. F. J. POYNTON showed a case of congenital symmetrical swellings on both heels in a girl. His view was that they were lipomata.

Dr. Pernet agreed.

Dr. CARPENTER showed a microscopical specimen of the liver from a case of icterus neonatorum in a child, aged 19 days. She beceme jaundiced on the second day. The navel was healthy; the stools were green. There was a systolic murmur over the left pulmonary area and in the left axilla. Post-mortem, the liver was not enlarged, but its section was a deep mahogany colour, with large visible veins. As far as the bile cucts could be traced, they were empty, and not obstructed. Microscopically, the liver walls were crammed with bile granules of an olive-grey colour. The fine bile capillaries were filled with inspissated bile in irregular-shaped masses, and showed a moniliform outline.

Dr. E. I. Spriggs said it was not necessary for there to be gross blockage for the production of obstructive jaundice, not only in the condition of toluylenediamine poisoning, but in acute yellow atrophy and phosphorus poisoning. It was probable that the jaundice occurred because of the catarrh of the small bile ducts. That might also account for liver cells containing particles of pigment.

Dr. Poynton referred to two cases which he brought before the section two years ago, in which the children got well. He thought that in cases of prolonged jauridice it was a mistake to vaccinate the child. He did not think that such cases were common.

Dr. PARKES WEBER referred to cases in which several children of the same parents had had jaundice, some

of them having died.
Dr. PORTER PARKINSON read a paper on three cases of

HENOCH'S PURPURA.

Case I was a boy, set. 8, who suffered from pain in the legs and abdomen, and a purpuric rash over most of the body and limbs. The spleen could be felt. The urine contained albumin, and occasionally a trace of blood and casts. The abdomen was tender in the epigastric and right iliac regions, and there was occasional vomiting. The child was treated with two injections of horse serum without any improvement, but recovered, and was discharged with the urine still

Case 2 was a boy, æt. 6, suffering from abdominal rain and vomiting. There were purpuric spots all over the extensor aspects of the limbs. The abdomen was not tender. The urine contained albumin and occasionally blood. In hospital he was suddenly attacked with abdominal pain, and the abdomen became tender in the left lumbar region. The pain continued on and off for nearly two months, occurring in crises every two days. Blood was found in the stools during most of this time. Later the face became puffy, especially the lips and eyelids, but the child began to slowly improve. The treatment was at first calcium chloride, and later three injections of horse serum. Two fresh groups of purpuric spots appeared while the child was taking calcium.

The third case, under the care of Dr. Charles Bolton, was a boy, æt. 6, who came into hospital with severe pain, and passing blood in the stools, with a measly non-purpuric rash and coryza. The next day he vomited and passed blood and mucus by the rectum. The abdomen becoming distended, it was thought that intussusception might be present, and the abdomen was opened, but none found. There were flecks of lymph in the peritoneum, with some evidence of general peritonitis. He died next day. At the necropsy there was general peritonitis, and on the small intestire were about 13 hæmorrhagic extravasations about the size of peas, and projecting on both outer and inner surfaces of the intestine. About a foot from the iliac valve there was a collection of much larger hæmorrhage. The small intestine was distended with gas, and the large intestine as far as the splenic flexure, where for about 6 in. it was quite dark from diffuse hæmorrhage, thickened, and looked almost gangrerous. The diagnosis lay between measles and Henoch's purpura, the suspicion of intussusception not being verified. Dr. Parkinson thought it was a case of purpura, but the absence of blood and albumin in the urine was unusual. The case supported a suggestion of Mr. Hugh Lett, made in the "Reports of the Society for the Study of Disease in Children" that it is advisable not to operate for intussusception in a case of Henoch's purpura unless an abdominal tumour can be felt.

Mr. Hugh Lett said the presence or absence of intussusception in Henoch's purpura was very important. He had reported a case in which intussusception had developed during the illness, and was reduced by operation. Seventeen days later another intussusception occurred, and the child died. thought that the crucial feature to be relied upon was

the presence of a sausage-shaped tumour, and that there should be no operation where a tumour was not felt. He had operated upon 28 cases of intussusception, in all of which he felt a tumour either from the abdomen or per rectum. In two or three of them he could not feel it without an anæsthetic. Surgical operation in Henoch's purpura was a very serious matter, and in some cases the patient had died of hæmorrhage from the wound. If he saw another case of undoubted intussusception with purpura, he would be inclined to try injection before operation.

Dr. LANGMEAD said that a tumour might be present simulating intussusception, but due to extravasation of blood, and Dr. E. I. SPRIGGS referred to another case showing this condition.

The CHAIRMAN thought the term, "Henoch's purpura," should be dropped, as the disease was simply purpura hæmorrhagica with abdominal symptoms, and Dr. PERNET agreed.

Mr. Lockhart Mummery showed a case of hyperplastic tuberculosis of the rectum in a boy, æt. 10. There was no pain or straining, but the bowels were loose, being opened as many as 20 times a day. There was no vomiting or wasting, and the appetite was good. Large masses could be felt projecting in the rectum from all sides, irregular in surface and shape. With the sigmoidoscope several ulcers about a third of an inch in diameter were seen, and had the appearance of tuberculous ulcerations. The whole of the mucosa of the rectum was red and swollen. The ulceration quickly cleared up under the influence of daily irrigation with weak antiseptics.

Dr. G. CARPENTER showed a case of scurvy in a boy, aged I year and 4 months. He had been reared on cow's milk and barley water for the first 3 months, and afterwards he had been given bread and milk, etc. He was admitted to hospital with a history of two falls, and was found to have a bruise over the right eye and a hæmatoma of the scalp with a cranial fracture. After 12 days he was discharged as cured, and continued in good health for six weeks, when he was re-admitted with a swelling in the left arm without any history of injury. The swelling extended from the shoulder on to the forearm. There were also marks of old hæmorrhages on the backs of both feet. The skiagram showed no fracture. He had improved very much on a suitable diet.

#### ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, APRIL 2ND, 1909.

The President, E. H. TWEEDY, in the Chair.

#### EXHIBITS.

Dr. Purefoy showed a small uterus removed for recurrent hæmorrhage from a patient, æt. 50, the mother of some children. She had been curetted in the first instance, and some thickened membrane had been removed. Some improvement was made, but the hæmorrhage recurred. Atmocausis was applied, but after another violent recurrence the uterus was removed. The specimen showed enormously thickened uterine walls, and the position of the endometrium indicated in section by a thin line showing almost complete absence of endometrium.

Dr. HOLMES recalled a case of Sir Arthur Macan's in which the hæmorrhage recurred after atmocausis and hysterectomy was performed. The vessels of the uterus were distinctly atheromatous, and it was doubtful if atmocausis would cure in such a condition.

Dr. JELLETT expressed great doubt as to the value of atmocausis in cases in which there was no endometrium. The hæmorrhages apparently came from blood vessels more or less diseased, and the superficial effect of atmocausis could not be permanent. He did not see how a second application of atmocausis would produce more than a temporary result as in the first application. He thought there was nothing left in such cases but hysterectomy.

Sir William Smyly said he saw a great theoretical difference between atmocausis and curetting. In the latter they removed the thickened membrane, and hoped that healthy membrane would grow. If not, they had to curette again. Atmocausis, however, destroyed the membrane and tissues of the uterus, and the depth of the slough depended on the heat of the steam and the duration of the application. If they did not get a sufficient slough the first time they had to repeat the application. In an old woman the obliteration of the uterus, which atmocausis was apt to cause, was desirable. He thought it was a very good method, and it was not so severe as hysterectomy.

Professor ALFRED SMITH said the effect of atmocausis was rather speculative, and in the great majority of cases they would find the best treatment to be

removal.

The President said that on two occasions he "atmocaused" two young women twice each, after they had been curetted ineffectively. The atmocausis failed on the first application and succeeded on the second in each case. He seldom "atmocaused" for more than fifteen seconds. It was better to do too little than too much, and on the second occasion they

might give twenty seconds with better results.
Dr. Sheill exhibited an improved material for liga-

turing the umbilical cord.

ADJOURNED DISCUSSION ON THE OBSTETRICAL AND GYNÆ-COLOGICAL REPORTS OF THE ROTUNDA HOSPITAL.

Professor ALFRED SMITH said that there was little difference between the report and those of twelve vears ago. Recent reports seemed to have become stereotyped. The present report, as a record of work done, was excellent, but he found that, for example, in the important subject of eclampsia, it showed no advance on what had been long published. They had been encouraged last year to hope for much from publication, but the subject was not mentioned in the report, and there was no furtherance of their knowledge as to the use of the operation in cases in which it was recommended. It was a most striking fact that the work done in the extern and intern departments was practically the same as regards results. Such a fact reflected great credit on all concerned, and was an immense change from olden times, when it was safer to be confined outside a maternity hospital than inside it. He thought the morbidity was high in operative cases in which the greatest possible care was

Sir William Smyly thought it was a very good thing that the report had assumed a stereotyped form, as it enabled them to make comparisons, and to note advances such as report showed. In 1886 there were four deaths out of fifteen abdominal sections; in the present report there was one out of ten times that number: that was a remarkable advance. In rupture of the uterus one thing in favour of gauze was that it could be used anywhere. If it only gave as good results as abdominal section it would be more useful to general practitioners. In pelvic deformities it was difficult to impress on men that they would not succeed in extracting a child, no matter what force was used, unless they waited until the head had passed the brim; if it would not pass the brim it was not a case for forceps. He thought the report was the very best he had seen, both as to the matter it contained and the way in which it was brought out.

Dr. KIDD expressed extreme interest in the account of the treatment of rupture of the uterus, as he had seen cases in which unfavourable results had followed an attempt to relieve the patient by abdominal section, and he would be inclined to follow the course adopted by Dr. Tweedy. The case of pernicious vomiting seemed to him to differ very much from the classical symptoms of the condition, as the patient was described as being highly neurasthenic, and having had a fright. There were 235 abortions in the extern department, and only forty in the intern, although the total numbers attended were practically the same in each department. He thought that was due to women staying at home in preference to going to the institution. He observed that there were three and a-half times more adherent placentas in the extern than in the intern department. Probably undue efforts were made to expel the placenta, with the result that the uterus was probably made to contract and incarcerate

the placenta, and the student may have rushed to the conclusion that it was adherent. He thought the morbidity table served to emphasise the danger of the introduction of the hand into the cavity of the uterus. When internal version was resorted to the mortality increased in accordance with the amount of hand and arm introduced.

Dr. SPENCER SHEILL said he did not think the death in the case of Cæsarean section could be put down to obstetrical shock. It was significant that the dilated condition of the uterus preceded rather than

followed the general shock. Under the headings of "Pernicious Vomiting" and "Eclampsia" it was mentioned in the report that the urine of the patients contained albumin, but there was no mention of the output of urea or ammonia, which is considered to be of importance in diagnosing the severity of a case. H= (Dr. Sheill) makes a practice of estimating the output of urea on the appearance of the first sign or

symptom of toxemia, and finds it of great value. Also in pernicious vomiting, if the percentage of ammonia reaches eight or ten of the total nitrogen excreted, then it is an indication for emptying the uterus.

Dr. Pure or said he would not at that late hour occupy the time of the Section with lengthened remarks on this most excellent report. He wished to point out that there was no figure on the cover or in the body of the report indicating the year to which it referred. The absence of some tables generally present in former reports, and useful for purposes of comparison, was reports, and useful for purposes of comparison, was to him a cause of regret. In applying a gauze tampon in cases of rupture, he disapproved of the method advised by Dr. Tweedy. The gauze should be introduced gradually, guided by the fingers of the left hand, using enough to act as a drain, but not so much as to prevent the gradual closure of the rent. Dr. M'Clintock's paper on rupture of the vagina is well worthy of perusal.

Dr. Holmes said the carcinoma cases made a remarkable record, and showed how fine the technique of

the hospital is.

Dr. Nell said he was present at the Cæsarean section already mentioned. At the first look he section already inentioned. At the hist look in thought the patient was suffering from the anæsthetic more than from anything else; but she was a very badly formed woman. He had seen cases of rupture in which hysterectomy had been done unsuccessfully, and he had seen cases in which plugging was very successful. It was creditable to see eight cases of placenta prævia without maternal death, but there were many cases of death of the child. The tearing of the placenta took away any chance the child might have, as it would bleed to death through the placenta.

Dr. TREVOR SMITH said the case of Cæsarean section was not at all a healthy woman, and the death was due, in his opinion, to the anæsthetic, but not through

que, in nis opinion, to the anæsthetic, but not through any fault of the anæsthetist.

Dr. Jellett said there were very few reports of any hospital of the kind that could produce the statistics shown in the tables of eclampsia and Wertheim's operation. They stood out as important proofs of what could be done by careful treatment and processful operation. He thought there was nothing successful operation. He thought there was nothing so important as keeping reports stereotyped for purposes of comparison, though not excluding fresh matter. He observed the omission of some tables which were formerly included, such as those on pro-lapse of the cord, post-partum hæmorrhage, and the sex of twins. In the table of placenta prævia there was a case of a central placenta prævia which was noticeable as to the fœtus being born alive, and he would like to know if the placenta was perforated, and what its position was. He had not done Lawson Tait's operation, in the exact way described by him, for a very long time. He always looked for the levator ani muscle and brought it down. The proportion in which it could not be found was very

The Master of the Rotunda, in reply, said he made it his object to take up one or two fresh subjects in each report, and he had dealt with the treatment of eclampsia the previous year. His mortality was 11 per cent., as compared with 35 per cent. twenty years ago. He had not dealt with publictomy, as they had not had a case during the year. He dealt with it fully last year, when they had five cases. He preferred Cæsarean section as an easier and safer operation if he got the case in time. His indication for performing publiotomy arose when he was sure he could not get a living child save by enlarging the pelvis. Ether was used in the case of Cæsarean section that died. It was an extraordinary uterus, thin-walled and flabby, yet without hæmorrhage. The placenta was firmly adherent. Professor Smith was surprised that they should have a greater morbidity after the application of forceps than in normal delivery. They, however, maintained that the less they interfered the smaller the morbidity. In spite of all precautions they could not get as small a rate of morbidity as when they left the patient alone, which proved that they had not reached the perfection of obstetrical technique. They had estimated the free urea and urea in its form of ammonia, but it had not led them to any conclusion. Others were working on the subject, and they would be glad to learn from them. Without doubt the less experienced a man was the more cases of adherent placenta he would meet. He had not seen a table of placenta prævia that did not show a big infantile mortality, and he had seen none that was less than their own. The child was probably dead before they began to turn. It was usually a premature child, and he was afraid they would always have a high mortality no matter what treatment they adopted. In the central case they went through the placenta. The foot was brought through the rent; the child did not bleed to death, as the placental hæmorrhage was stopped by the leg that was pulled through the hole.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

#### FRANCE.

Paris, April 18th, 1909,
TREATMENT OF GOUT BY ARTICULAR PUNCTURE. SINCE 1795, when Tennant and Pearson discovered the presence of uric acid in the articulations of

patients suffering from gout, and more especially since the memorable treatise of Garrod, the majority of authors have admitted that gout is due to an exaggerated production of uric acid in the organism or a rupture of the equilibrium established between the a rupture of the equilibrium established between the production of this acid and its elimination. Guided by this principle, MM. Lumiere and Gelibert considered that it was not sufficient to facilitate the elimination of uric acid by the natural outlets, that it was better practice to extract it directly from the large joints. A puncture made according to the rules of asepsy could cause no risk to the patient. Accordingly, said these authors before the Société de Thérapeutique, for the last five years, each time that the opportunity presented itself, they systematically tapped the knees of gouty patients with constant success. success.

Success.

The immediate results of the operations were: Sudden suppression of pain, rapid fall of temperature, definite termination of the attack. The relief following the puncture was almost instantaneous. As soon as the evacuation of the effusion was effected, the patient could move the limb freely without any pain and considered himself cured.

It is not that hydrarthropic of the knee in patients.

It is rare that hydrarthrosis of the knee in patients It is rare that hydrarthrosis of the knee in patients suffering from gout is not accompanied by a rise of temperature, either locally or generally. A few minutes after the operation it begins to fall, and at the end of three or four hours the temperature is normal. That the liquid is the direct cause of the fever is placed beyond doubt, as MM. Lumiere and Calibert injected as small quantity into animals and Gelibert injected a small quantity into animals and found that the temperature rose 2 or 3 degrees in a

In very acute forms of hydrarthrosis, due to gout, the tapping of a large joint terminated the attack. Where the effusion was absorbed automatically, other joints were attacked in succession, and the malady

dragged on for weeks and months until the reappearance of the hydrarthrosis, when the above operation finally dissipated all accidents.

As to the moment for practising the tapping of the joint, the authors recommend that it should be done as soon as the presence of liquid is clearly diagnosed, without waiting for complete distention of the synovia, as the liquid might become absorbed in a few hours. The most favourable point for introduc-ing the needle would be the external border of the patella. In any case, puncture of the cul de sac beneath the triceps should be avoided, as it is generally independent of the large articular synovial membrane.

The instruments necessary to the operation are simple: An aspirator, Roux or Potain, with a capillary needle of two and a-half inches. The quantity of serosity withdrawn varies between one and four ounces. When the instrument is withdrawn a piece of cotton moistened with collodion and iodoform closes the little aperture, and the knee is enveloped in cotton wool fixed by a bandage. The patient is enjoined to keep his bed two or three days. The distant results of this treatment are important. Patients affirmed that these attacks were much less frequent and less violent. One man had eight or ten attacks yearly for thirty years; after the first tapping he passed two years without a seizure.

Another important point is that no deposits form in the articulations. After the puncture the articulation becomes as free as before the attack, while no gouty concretions form on the fringes of the synovial membrane nor on any part of the body, whereas, under the classical treatment, such deposits of urates are the rule, amounting in many cases to

established infirmity.

The liquid withdrawn from the joint is of citron yellow, and contains chloride of sodium, phosphates, and traces of sulphates and carbonates. Urea varies in considerable proportions, but no uric acid has been

The liquid is eminently toxic; injected into the veins of a rabbit, in doses varying between one and two drachms per lb. weight of the animal, it killed it in a few hours after provoking a considerable rise in the temperature.

To conclude, MM. Lumiere and Gelibert affirm that from the constancy of the results obtained, the sim-plicity and benignity of the operation, articular puncture constitutes, in every case where it is pos-sible, the best curative treatment of an attack of

SYPHILITIC INFANTS. Prof. Comby, the well-known authority on children's diseases, recommends the following method of treating hereditary syphilis in infants:—Friction during five minutes each day with a flannel on which is spread mercurial ointment of about the size of a small nut. The regions successively chosen are the right and left side of the abdomen, both axillæ, the right and left inguinal regions, the internal surface of the thighs, so as not to return for eight days to the place already treated.

The flannel should be left in situ after each friction. After twelve hours the region should be washed with soap and water. During the first year the ointment should be applied daily, with an interruption of a fortnight every three months. The second year, one month's treatment and one month's rest. During the first months a little of the following ointment should be introduced into each nostril morning and evening:

Calomel, ½ dr.
Vaseline, 1 oz.
If there are papulæ on the skin, a bath of sublimate should be given daily for ten days:

Corrosive sublimate, ½ dr. Hydrochl. of ammonia, 1 dr.

The immersion should last ten minutes, at a tempe-

rature of 95°.

Prof. Comby never observed any accident with this treatment, which was always successful.

LIEUTENANT-COLONEL J. D. LLOYD, of Chirk, has received from the King the newly-instituted Territorial Decoration for long and meritorious service.

#### GERMANY.

Berlin, April 18th, 1909.

AT the Verein für Innere Medizin, Hr. His read a paper on

GOUT AND RHEUMATISM.

He said, by way of introduction, that the classification of the chronic arthritides had ever been a crux medicorum. It could not be undertaken without a certain caprice, whence arose the confusion of the nomenclature, which corresponded to the prevailing views as to ætiology and pathology, and the treatment. They were considered as diseases of tissue change, and treated dietetically and by appropriate medicines. If we went back to modern history we saw that in the first half of the last century, in France, the idea of arthritism was formulated, of which all the various manifestations formed a part. About the middle of the century general interest turned to this subject, and excellent monographs appeared, amongst which that of Garrod was to be specially mentioned, the great value of which was that it severed gout from the common conception. Later the essential part of the chronic joint affections was announced to be a failure of purin tissue change, and precision was attempted by means of investigations. Undoubtedly in these diseases uric acid was the material that could be grasped, but it was not the only materia peccans, for we found a number of symptoms that had nothing to do with it. Perhaps toxic products made their appearance in the diseases of purin tissue change. It might be a general disturbance of the organism; the affection might depend on an improper mode of life, from excesses in eating, and the use of spirituous liquors. Observation of numerous cases, however, taught that patients did not always get worse, and so that we were compelled to assume a certain congenital

or acquired tendency.

Was the disturbance of purin tissue change the only disturbance? We found in connection with arteriosclerosis, obesity, diabetes, etc., for which reason the idea of a constitutional disease was retained. In opposition to this, Virchow especially had given prominence to the anatomical idea, and defended the notion that these were only diseases of organs, the rôle being played in the cells. Now it was at least probable, but by no means proven, that anomalies of the cells were the foundation of disease, but which were not visible to the eye. Ottomar Rosenbach and Martin had now added new contents to the idea of a constitutional disease; to it belonged idiosyncrasy, immunity, etc. But a certain disposition to forms of disease which we call a diathesis could not be denied. Wherefore, the French idea of arthritism had been retained and developed, and had now been accepted by the physicians of North America and Italy. It had now attained excessive dimensions; everything relating to constitutional anomalies was grouped within it. Quite recently it had been more sharply defined in Lyons as a condition in which uric acid and oxalic acid were present in the blood, or there was a diminu-

tion of oxydation.

The chronic arthritides might appear in manifold form. From clinical points of view we might divide them into:—(1) Chronic affections of joints after acute articular rheumatism, secondary chronic articular rheumatism; (a) primary chronic polyarthritis, (a) with exudation in the cavities of the joints and synovial growths, (b) without these; (3) the chronic arthritides peculiar to old age; (4) the traumatic form; (5) Heberden's nodules. From the anatomical point of view we distinguished (a) diseases that began in the cartilage, in which the capsule was but little and secondarily affected; (b) diseases that began in the and secondarily affected; (b) diseases that began in the synovia, and passed on to the bones secondarily. Ætiologically we distinguished diseases: (1) from injury and after hæmorrhages and inflammations, etc.; (2) after acute rheumatism; (3) after infectious diseases, such as scarlatina, typhoid, pneumonia, etc., and especially after chronic infectious diseases, such as gonorrhœa, syphilis, tuberculosis. As regarded the latter, its causative rôle must be considered doubtful, notwithstanding the fact that in this respect it was given a prominent place by many authors. The frequent occurrence of endocarditis was very reminiscent

of infection, although specific bacteria had not yet been found in it.

After taking away the cases with a known ætiology, there still remained a large number in which no ætiological trace could be discovered. When now hereditary or family tendencies as to gout and chronic arthritides had been observed, we could then speak of a diathesis. This was so especially as regarded Heberden's nodules, which bore a relation to the endogenous diseases.

How, then, could the idea of a common cause be more sharply defined? Firstly, by anatomical examination. It was often seen that in diseases that must be reckoned as arthritisms there were arthritic changes in the joints. In 97 cases of the kind examined by the speaker, such degenerations were found in 62, and not infrequently in very young people, under the influence, therefore, of some injury of nutrition of the cartilage

of nutrition of the cartilage.

A further question was whether the purin tissue change in these patients showed any deviation from the normal. He was able to prove the deviation in six of the cases examined, amongst others in an old drinker who had formerly had attacks of gout, in one case with arterial hypertension, in two females with progressive ineumatism, and in one alcoholic with sciatica.

The speaker then proceeded to the differential diagnosis between gout and rheumatism. There were two methods of investigation at hand—(1) Examination by Röntgen rays, and (2) examination of the purin tissue change. The first-named method was first recommended by Potain. He described lacunæ in the bones as a characteristic sign of gout. The speaker could not recognise this as a characteristic of gout, as, according to his own investigations, such lacunæ were present in bones in chronic arthritis and in the non-arthritic (illustrations of preparations were here shown on the screen). On the other hand, examination of the purin changes yielded a good mark for the differential diagnosis between gout and rheumatism. Where changes of purin tissue change could be proved, the case was one of true gout.

What therapeutical consequences might be drawn from the foregoing considerations? Very many physicians ordered a lacto-vegetable diet in these groups of diseases. It must be conceded that in the case of strong people we got a favourable effect in this way, but in the severer forms we might easily set up a condition of defective nutrition, which in weakly people was very dangerous. In true gout a purin-poor ciet was indicated.

#### AUSTRIA.

#### Vienna, April 18th, 1909.

WORKERS' TETANY.

Two cases of tetany due to the occupation of the patients were presented to the members of the Gesell-schaft der Aerzte by Falta and Rudinger, which were interesting subjects for discussion owing to the experimental treatment with adrenalin. Tetany is still in the chrysalis stage respecting its ætiology, and each investigator adds a qualifying term to convey his own opinion.

Jaksch and Frankl-Hochwart have repeatedly affirmed that shoemakers are more subject to this disease than others. They found by investigation that out of 314 males affected, 141 were shoemakers, and 41 tailors, hence the term "schusterkrampf."

Whether this incidence is due to the nature of the work, or whether the atmosphere and surroundings favour the formation of the noxe, none seem yet to be able to explain, which largely accounts for the increase of our terminology. Genuine tetany, according to the experiments of Eiselsberg on animals, can be produced by the extirpation of the thyroid, and Billroth's operations on the human subject confirmed this opinion; but how the mucin accumulates in the body by any particular trade is not yet clear. Falta and Rudinger were anxious to test the circulation, and, with this in view, injected adrenalin. In the normal subject 1 milligramme, when injected subcutaneously, raises the pressure suddenly. In ten normal cases he

injected, eight of them rose to their maximum within 6 and 8 minutes, and, according to Riva-Rocci's method, would support 30 to 60 milligrammes, or 11.8 to 23.6 in. of mercury. This exalted bloodpressure will last a quarter to three-quarters of an hour, and then gradually subside.

In four cases of tetany so treated the results were variable. In all the cases the blood pressure rose to its maximum within 2 to 3 minutes, and in one of the cases presented the pressure supported oo to 180 millimetres of mercury, equal to 34 or 70.8 in.; in the other case the pressure ranged between 115 to 165 millimetres, while the others varied between these extremes. After the injections there was an exacerbation of the tetanic contractions, as well as the prominent symptoms of Chvostek and Trousseau. All had parasthesia, with cramping in the hands, but not so great in the lower extremities. The contractions were lighter in the muscles of the abdomen and glottis, though sometimes dangerously severe.

#### Loss of the Feeling of Touch.

Flesch brought in a peculiar case of teleangiectasis causing the loss of the feeling of touch in the fingers. The patient, a male, æt. 56, had a large teleangiectatic swelling, extending from the right eyelid back across the parietal bone to the occipital; the right eyeball was deeply depressed in the orbit, surrounded by a convolution of veins almost fixing the movement of the bulbus, while the pupil reacted normally. Over the upper part of the nose there was also a doughy swelling, but firm beneath when pressed. On closer examination the whole of the parietal bone seemed to be absorbed on the outer surface, exposing the diploë. From the elastic wave, on deep impressions, it was concluded that the parietal bone was entirely absorbed or transformed to a fibrous covering for the cerebrum. There were also large convolutions of veins in the naso-pharyngeal space hanging down like grapes behind the gums. When the jugular vein was slightly compressed the caverns of blood were enormously increased, causing fulness and vertigo. When the head was lowered or compressed, there was a feeling of fulness while coughing made the veins jump up.

From this inquiry the connection between the hand and angioma became clear. It appears this racemose angioma had been there for years, and had acted on the diploë till it became absorbed, after which the arachnoidal vessels would be affected, and finally the cortical substance of the brain, with the subsequent lesion of paralysis of feeling in the hands.

#### ANAPHYLAXIS.

Biedl and Kraus gave the members of the Gesell-schaft an exhaustive account of their laboratory experiments with peptones, particularly Witte's peptone, which contains 70 to 80 per cent. of the substance. By ir jecting this peptone an antiphylaxis for serum was induced. When the animal was saturated with the anaphylactic toxine it was insensible to the Witte peptone injections. They thought this did not prove that the toxines were alike, but it showed they were nearly related in some way. The hypothetical toxine of anaphylaxia and Witte peptone are physiologically related by the mode of attack, both paralysing the peripheral vasomotor apparatus with non-coagulation of the blood. The negative action of anti-anaphylaxia and immunising peptones shows that new toxines have no effect on the paralysed muscles. The paralysis gradually recovers, and the blood pressure returns to its normal state, but the weakness is easily induced by interfering with the spinal cord or splanchnic nerve. They concluded by reiterating that anaphylactic intoxication was physiologically identical with the Witte peptone toxine.

Escherich was of opinion that the serum disease had a great similarity to peptone intoxication, as shown by Pirquet and Schick. They showed that any foreign serum when injected liberated analbuminoid serum that was readily thrown off.

Biedl said the anaphylactic reaction liberated an anaphylactic toxine, which acted as an anti-anaphylactic on other serum, while the peptone produced a sort of degenerate product which had the property of increasing the sensibility of other animals.

#### LETTERS TO THE EDITOR.

[We do not hold curselves responsible for the opinions expressed by our Correspondents.]

THE POOR-LAW MEDICAL SERVICE.

To the Editor of The Medical Press and Circular. SIR,—There was a day not so long ago when to have the Times on one's side in any project of reform affecting the welfare of the people was to make tolerably sure of ultimate victory. Editorially the Times is as strong as ever; but from causes that you, Sir, on several occasions have sufficiently pointed out, the prestige of the erstwhile leading journal has gone; and an article powerful as it may inherently be from its matter and literary form now effects little more in the way of influencing public opinion than the spicy paragraphs of the most vulgar of half-penny contemporaries that is written down to the level of the intellect of 'Arry. In the Times of to-day appears a most admirable article on Dr. McVail's report which has been already noticed in your paper. The article fully exposes the enormous waste of power and money involved in the present system; and the lamentable loss of efficiency from the failure to regard the provision of medical attendance for the sick poor as a matter of national concern, likely to exert an appreciable influence upon the national welfare. appreciable induence upon the national weitare. The miserable position of the Poor-law Medical Officer is clearly exposed. There are no graduations of rank among its members; no official recognition of good work, no condemnation of inefficiency or neglect. The Poor-law Medical Officer is at present the servant of the Board of Guardians; and the Boards are too often dominated by mean, ignorant, and selfish men incapable of understanding the importance of the laws they are supposed to administer, or ance of the laws they are supposed to administer, or capable of obstructing their enforcement to further their own sordid ends. They have ample power to coerce their officer into docility. He must obey or go. There is no public opinion to appeal to with effect. The case for Poor-law Medical Reform, like the case for medical law reform all through, the case for reasonable treatment by the State of all its medical servants, and of all medical practitioners from whom it exacts so much—the case for justice to the profession is overwhelming. It is the fault of the profession that reform does not come. It is their duty to the State, and to the masses whose sufferings from the present condition of things they alone are fully cognisant of, to force the facts to the front, and demand reform. Would that I could see any signs of movement in this direction among the profession. Until such signs appear I must, I fear, continue to sign myself,

April 15th, 1909.

A Poor Parish Doctor.

# MILITARY & NAVAL MEDICAL NOTES.

A BLOCK at the Military Hospital, Hilsea, is to be built at a cost of  $\pounds 3,150$ .

LIEUTENANT-COLONEL R. E. MONSE, R.A.M.C., has been appointed to charge of the Military Hospital, Cosham, Hants.

SURGEON-GENERAL P. H. BENSON, I.M.S., has been awarded a good service pension in succession to Surgeon-General J. P. Greeney, retired.

Dr. W. S. A. GRIFFITH, Phys. Accoucheur, St. Bartholomew's Hospital, has been appointed by the Army Medical Council Consulting Gynæcologist to Queen Alexandra's Military Hospital.

A BOOK of some importance to officers and soldiers serving in India has been written by Major R. J. Blackham, R.A.M.C., Divisional Sanitary Officer, Peshawar. Its title is "Military Sanitation for Soldiers Serving in Hot Climates." It is specially

intended to aid officers studying for subject J, and will contain sections on communicable diseases of soldiers, air, water, food, clothing care of barracks, the camp, and the march, disinfection and disinfectants, etc., etc.

MAJOR G. CRAWFORD, R.A.M.C., recently gave a very interesting address at the Soldiers' and Sailors' Institute, Valetta, Malta, on his experiences while in command of the Field Hospital which was despatched to Messina after the earthquake to afford aid to the sufferers.

THE Pasteur Institute in Burma has received subscriptions amounting to one lakh and 17,000 rupees. The benefit derived by the population, civil and military, from these institutions throughout India is very great, and it is not surprising to find subscriptions flowing in so generously.

SURGEON GERALD C. CROSS, Royal Navy, having completed two years' service as junior medical officer at Sheerness Dockyard, is succeeded by Surgeon E. R. Townsend, Royal Navy, who is completing a three months' course of study at a civil hospital. Surgeon G. C. Cross joins the torpedo-gunboat Leda.

THE discontent among sailors of H.M. ships of war regarding hospital stoppages led to a question being asked, in the House of Commons, by Sir John Benn, of the First Lord of the Admiralty as to whether the latter was aware of the resentments in regard to these stoppages in cases where illness was not in any way attributable to the misconduct of the patient, and whether the First Lord would make inquiries with a view to remedying the alleged grievance. Mr. McKenna (the First Lord of the Admiralty) said that the subject was now being considered by the Board of Admiralty.

Gratifying results have attended the movement for inducing officers and men in the Dockyard at Devon-tort to go through a course of instruction to qualify for the St. John's Ambulance Association Certificate. The first class was formed by 16. of whom 13 went in for the examination with 10 successes for "First Aid" Certificates. Praise is due to Engineer-Commander Emdin, at whose invitation Major H. Blackman, R.A.M.C., delivered two explanatory lectures with lantern views. The examination was conducted by a retired Deputy Inspector-General, Royal Navy, Dr. Coates, of Dawlish.

The usual hustle and bustle of Army Medical Mobilisation seems to have occurred in Vienna during the Servo-Austrian scare. Certain defects in the Medical Corps of the Austrian Army were exposed some little time ago, particularly the insufficiency of staff surgeons. Haste was made to put things right and up to modern requirements. All practitioners between 24 and 36 years were warned to re-enter the Army. In the Austrian Army, on mobilisation, one surgeon is allotted to 200 men—about 30 per cent. of the civil population doctors are withdrawn on mobilisation.

#### **OBITUARY.**

CLAUDIUS GALEN WHEELHOUSE, F.R.C.S., LL.D., D.Sc.

MEMBERS of the medical profession in general will share the regret which the citizens of Leeds felt at the death, in his 83rd year, of Mr. C. G. Wheelhouse, who, after nearly half a century's strenuous work, retired to enjoy well-earned rest in his country home at Filey in 1889.

Claudius Galen Wheelhouse, F.R.C.S., LL.D., D.Sc., was the second son of Mr. James Wheelhouse, surgeon. On October 1st, 1846, young Wheelhouse, already an ardent student, took his place on the benches of the Leeds School of Medicine, where he remained for three years. During his

connection with the Medical School, Mr. Wheel-house, filled in succession the Chairs of General Anatomy, Physiology, and Surgery, and he also found time to engage largely in private tuition. For many years few of the pupils of the Leeds School of Medicine presented themselves for examination at the Royal College of Surgeons until they had his assurance that they were fit to do so, and even to this day many of his old pupils will remember with gratitude the care he took in their preparation. The high posi-tion to which the Leeds School of Medicine attained was to a very large extent due to the unremitting zeal which Mr. Wheelhouse took in nursing the institution through its early difficulties, and he is pronounced by the students of that day to have been one of the best teachers of anatomy, physiology, and surgery that the school ever possessed, his lectures and thorough coaching of pupils being singularly successful. The dacility with which he imparted his knowledge on any subject, as lecturer or in private, was extraordinary. On two occasions he held the position of President of the School, and from first to last, for a period of twenty years, he took the deepest personal concern in everything that has helped to make this medical academy an institution of which Leeds and the whole

country are justly proud.

In March, 1864, he was elected, with the late Mr.

Nunneley and Mr. T. Pridgin Teale, Surgeon to the
Leeds Infirmary, an office which he retained for

twenty years.

When, in 1885, direct representation of the profession on the General Council of Medical Education and Registration was, after long-continued agitation in Parliament, at last obtained, he was elected at the head of a large poll of the whole profession the first direct representative for England. This honourable position he held for ten years, and only relinquished it when advancing years warned him that the duties could be better performed by a younger man.

#### JAMES O'BRIEN KOUGH, M.R.C.S., L.S.A.

WE regret to record the death, on April 2nd, at Wolverhampton, of Dr. James O'Brien Kough. The deceased gentleman was trained for the medical profession at St. Bartholomew's Hospital, London, and became a licentiate of the Society of Apothecaries of London in 1860, and a member of the Royal College of Surgeons of England in 1861. He had thus been a registered medical practitioner for nearly half a His first medical appointment was that of century. Assistant House Surgeon of the Salop Infirmary, and next he was House Surgeon of the Wolverhampton and Staffordshire General Hospital, and subsequently one of the honorary surgeons of the institution. For many years he had also been in private practice in Wolverhampton. It may be mentioned that he was an old Shrewsbury schoolboy, to which school he was sent by the late Sir James Paget. There he formed lasting friendships with many men who have since risen to eminence. Mr. Kough was personally acquainted with many men whose names are Lousehold words, such, for example, as Charles Dickens and Charles Darwin. He was an intense lover of Nature, and an ardent horticulturist. He had an extensive, varied, and highly interesting collection of exotic plants in cultivation—in fact, it is doubtful if a much more interesting private collection of horticultural specimens under glass could be found in the Midlands.

#### ROBERT JAMES CARTER, M.D.LOND.

THE death of Dr. Robert James Carter has taken place at his residence at St. John's Wood, N.W., at skin Hospital and a House Surgeon at the Soho Male Lock Hospital. Formerly he had held appointments as Resident Medical Officer at the Royal Hospital for Children and Women, Clinical Assistant at the Evelina Hospital, House Surgeon at King's College Hospital, and Surgeon to the Clan Line Steamship Company. His medical education was carried out at King's College Hospital, whence he took the degree of M.B. Lond., and where he was a popular and well-known student.

EDWARD PENROSE TWYFORD, M.D.ED., J.P. WE regret to announce that Dr. E. P. Twyford, J.P., late of St. Helens, died, on April 8th, at his residence at Birkdale, Southport. Dr. Twyford had been taken ill on April 1st, when his only daughter died from pneumonia. This sad event had a distressing effect upon Dr. Twyford, who would have completed his 78th year next month. He developed pneumonia, and it was soon evident he was in a hopeless state. Twyford had been in practice at St. Helens over 55 years, and he was a county and borough magistrate, and widely respected.

#### THOMAS WILLIAM NUNN, F.R.C.S.

WE regret to announce that, after a short illness, Mr. Thomas William Nunn, consulting surgeon to the Middlesex Hospital, died of heart failure at Kneesworth, Royston, last week. Before being appointed to the medical staff of Middlesex Hospital, Mr. Nunn was surgeon to the Westminster Western Dispensary, and in later life was also a consulting surgeon to the Central London Throat Hospital and to the London Hospital for Skin Diseases. He saw a great deal of early practice in Paris, where he was at the time of the Commune. He was formerly a lieutenant of the 3rd Middlesex Militia and hon. surgeon-major of the Volunteer Forces. He contributed various papers to medical literature, his chief contributions being those relating to the treatment of cancer, and in 1899 he published in book form the reports of 1,000 cases from the registers of Middlesex Hospital. Mr. Nunn was a past Vice-President of the Pathological Society and a medical associate, and member of the teaching staff of the anatomical department of King's College. He qualified as a member of the Royal College of Surgeons in 1846, and as a Fellow in 1857, and was 84 years of age.

#### CHARLES BELL TAYLOR, M.D.EDIN., M.R.C.S. ENG.

We regret to announce the death of Dr. Charles Bell Taylor, of Nottingham, who for many years was in practice in the Midland Counties as an ophthalmic

Dr. Taylor was the son of a veterinary surgeon of Nottingham, and received his medical education at the University of Edinburgh and in Paris. He became a member of the Royal College of Surgeons of England in 1852, and M.D. at Edinburgh in 1854. In 1859 he was appointed a surgeon to the then newlyestablished Eye Infirmary at Nottingham. Dr. Taylor entered upon the work of his speciality at a time when it was undergoing great changes as a conse-quence of improved methods of investigation, and for fifty years he kept himself well abreast of its advances, whether as regards science or practice. Notwithstanding his advanced age, he continued to see patients, and he was quite recently consulted by "General" Booth, and advised the operation which has since been successfully performed. Dr. Taylor was unmarried. He made many contributions to current medical literature, and was the author of a book of "Clinical Lectures on Diseases of the Eye."

SIMEON SNELL, F.R.C.S.Edin., M.R.C.S.Eng., J.P.

We regret to announce the death of Mr. Simeon Snell, the well-known ophthalmic surgeon, of Sheffield, on Saturday last. Deceased, who received his medical education at Leeds and at Guy's Hospital, London, took the M.R.C.S.Eng. in 1872, and the F.R.C.S.Edin. in 1892. He held many ophthalmic appointments, including that of the Royal Infirmary of Sheffield. At one time he edited the Quarterly Medical Journal, and was the author of numerous medical treatises and several books. Some of his best known work was that connected with miners' nystagmus. Among many honorary posts filled with distinction by Mr. Snell were that of President of the Ophthalmological Society and of President of the British Medical Association (1900). In our next issue we hope to give a more extended notice of his busy and useful career from the pen of a personal friend.

### MEDICAL NEWS IN BRIEF.

#### The Tuberculosis Exhibition

THE Tuberculosis Exhibition, inaugurated by the Women's National Health Association, will be held in the Rotunda Rooms (not in the Rotunda Hospital, as announced by a contemporary), from April 20th-22nd. At a meeting already held the following execu-Fannin, and Mr. T. C. Harrington, M.P., Honorary Secretaries; and at the following executive officers and Mr. J. C. Harrington, M.P., Honorary Secretaries; and at the following meeting of the Executive Committee (co. Avril 18th) the project secretaries. Executive Committee (on April 7th) the various sections of the Exhibition were allocated to managers and sub-committees as follows:—Pathological Section, Professor E. J. McWeeney. Veterinary Section, Mr. C. Allen, Mr. A. Watson, and Mr. J. Wilkinson; Statistical Section, Sir R. E. Matheson; Literature Section, Dr. A. G. Boyd; Appliances Section, Sir W. J. Thompson; Hygiene Section, Mr. George Fletcher, Dr. R. J. Rowlette, and Professor F. T. Heuston. Food Section, Professor W. H. Thompson; Domestic Science Section, Professor W. H. Inompson;
Domestic Science Section, Mrs. Rushton, Miss Fletcher,
and Miss McNeill. It was then announced that Dr.
E. W. Hope, Superintendent Medical Officer of
Health of Liverpool, would deliver a lecture on Tuesday, April 20th, and that Dr. Philips would lecture on the following evening. It was also decided that popular lectures should be delivered every evening, and that demonstrations of exhibits should be given frequently during the day.

#### Association of Medical Men Receiving Resident Patients.

THE annual general meeting of this Association was Dr. W. T. Reid in the chair. Dr. G. E. J. Crallan was elected President for the ensuing year, and Drs. Dove, Haynes, Still, Reid and Walsh, Vice-Presidents. The annual report presented by the Secretary was read and received. It showed a very catificatory increase in the work of the Association satisfactory increase in the work of the Association, the number of patients placed being nearly double than those of 1907. The demand for membership, however, was shown to continue to be higher than is commensurate with the applications received from patients. The report showed that, in spite of this encouraging evidence, the Association was far from receiving the support which it deserves at the hands of the profession, as being the only organisation of medical men formed for the purpose and established on the principles of self-help and mutual support, and also that it had nothing in common with commercial agencies, as any profits made became the property of the Association as a whole.

The financial position, which enabled the subscriptions to be lowered last year, shows that, in spite of this fact, and with increased advertising and clerical expenses, the balance brought over at the end of 1908

was almost double that of 1907.
Votes of thanks to the Chairman and Honorary Secretary brought the meeting to a close.

#### London School of Tropical Medicine.

This institution, which is affiliated with the University of London, is about to start an Advanced Course in Medical Zoology on May 1st; this will include Protozoology, Arthropodology, and Helminthology. The second course will commence on October 1st. Students who have attended the ordinary course are eligible, and others who satisfy the teachers in these subjects that they possess sufficient rudimentary know-ledge to benefit by these courses. The advanced course in each subject will begin at the expiration of General Medical Zoology, 1st week of the session; Protozoology, 4th week of the session; Arthropodology, 7th week of the session; Helminthology, 1oth week of the session. Arrangements are so made that the advanced course in all three subjects can be taken during the three months or the whole time may be

spent on one subject. Special arrangement may be made with the teachers where it is desired to spend more time on one branch to the exclusion of others, or to undertake research work in that subject.

Further particulars as to the course of study may be had on application to Dr. C. W. Daniels, Director at the School, Connaught Road, Albert Dock, E., or to the Secretary, at the Head Office, Seamen's Hospital, Greenwich, S.E.

#### National Lying-in Hospital, Dublin.

At a recent meeting of the Board of Governors of this hospital, Dr. Andrew Horne, President of the Royal College of Physicians, and Dr. Reginald White were appointed Joint-Masters for the ensuing seven years. Dr. Horne has already held the post since the foundation of the hospital, and Dr. White takes the place formerly held by Dr. Barry.

#### Royal College of Surgeons in Ireland.—Election of Examiners.

NOTICE is hereby given that a meeting of Fellows will be held on Tuesday, May 4th, at half-past four o'clock, pursuant to the provisions of the Supplemental Charter, to witness the election of Examiners.

Graduates of any University which may be from time to time recognised by the College shall be eligible for election as Examiners in the subjects of General Education. All the other Examiners shall be Fellows or Licentiates of the College, or professors or lecturers in any School of Medicine recognised by the College.

Candidates are requested to lodge their applications in writing with the Registrar, at the College, on or before Tuesday, April 27th, at 10 a.m.

#### University of Durham.

THE following candidates have obtained the Degree of Doctor of Medicine.—Gilbert I. Cumberlege, M.B., B.S.Durh.; Robert A. Morris, M.B., B.S.Durh.; William W. Stainthorp, M.B., B.S.Durh.; Percy E. Turner, M.B., B.S.Durh.

Degree of Doctor of Medicine for Practitioners of Degree of Doctor of Medicine for Practitioners of Fifteen Years' Standing.—Graham T. B. Blick, M.R.C.S., L.R.C.P., L.S.A.; Alfred A. Hill, L.R.C.P. and S., L.F.P.S., G., Ernest W. G. Masterman, F.R.C.S., L.R.C.P., D.P.H.; Edward J. F. Moore, M.R.C.S., L.R.C.P.; John P. Oliver, M.R.C.S., L.R.C.P.; Walter J. E. Sumpter, M.R.C.S., L.R.C.P., L.S.A

The Degree of Master of Surgery (M.S.) has been obtained by Bryden Glendining, M.B., B.S.Durh., F.R.C.S.

The following obtained the Degree of Bachelor of The following obtained the Degree of Bachelor of Medicine (M.B.).—Kenneth Bruce Allan, Harriett Amelia R. Apps, Eldred C. Braithwaite, Leonard F. Browne, Charles E. L. Burman, Leslie W. Evans, John R. D. Holtby, L.R.C.P. and S., E.; Henry F. Iliewicz, M.R.C.S., L.S.A.; Duncan M. Johnston, M.R.C.S., L.R.C.P., D.P.H.; Annie V. Mack, Jessie M. Murray, Friederike Rahtkens, William Rollin, L.R.C.P. and S., L.F.P.S., G.; Robert H. Smailwood (Rev.), M.A.; Theodore W. Stallybrass.

Degree of Bachelor of Surgery (B.S.).—Kenneth B. Degree of Bachelor of Surgery (B.S.).—Renneth R. Allan, Harriett A. R. Apps, Eldred C. Braithwaite, Leonard F. Browne, Charles E. L. Burman, Leslie W. Evans, John R. D. Holtby, L.R.C.P. and S.; Annie V. Mack, Jessie M. Murray, Friederike Rahtkens, William Rollin, L.R.C.P. and S., L.F.P.S., G.; Robert H. Smallwood (Rev.), M.A.; Theodore W.

Bachelor of Hygiene (B.Hy.).—Guy R. East, M.B.,

Bachelor of Hygiene (B.Hy.).—Guy R. East, M.B., B.S.Durh.; John T. Johnson, M.D., B.S.Durh.; William R. Macdonald, M.B., Ch.B.Ed.; Elizabeth N. Niel, M.B., B.S.Durh.; Arthur J. R. O'Brien, M.B., Ch.B.Ed.; Gertrude E. O'Brien, M.B., B.S.Durh. And the following received the Diploma in Public Health (D.P.H.).—Guy R. East, M.B., B.S.Durh.; John T. Johnson, M.D., B.S.Durh.; William R. Macdonald, M.B., Ch.B.Ed.; Elizabeth N. Niel, M.B., B.S.Durh.; Arthur J. R. O'Brien, M.B., Ch.B.Ed.; Gertrude E. O'Brien, M.B., B.S.Durh.

#### **NOTICES TO** CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Institut, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

#### SUBSCRIPTIONS.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12. Messrs. Dewson and Sons are our special agents for Canada. ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessary for publication but as evidence of identity.

ADVARTICEMENTS.

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ADVARTICEMENTS.

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CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Edutor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office, when sending subscriptions the same rue applies as to office; these should be addressed to the Publisher.

Medicus (Market Harborough)—There is always room for a

MEDICUS (Market Harborough).—There is always room for a practical scheme for the reliet of human suffering. It will be well to take careful precautions, however, that the benefit of one class does not involve any injury to another, least of all to the profession to which our correspondent belongs.

VISITOR (Wimbledon).—The Medical Officer of the district is the proper person to apply to for information. You cannot compel your landlord to undertake the selling right of the drainage, unless you secured a warranty before signing the lease.

G. E. M. (Somerset).—You will find no better climate for your patient than that of the Tyrol. The scenery is magnificent, the air bracing, and the natives a hospitable and charming race. Innsbruck is the capital, and forms an excellent centre for the country. If you write to Herr Karl Landsee, of Innsbruck, Austrian Tyrol, he will supply you with all particulars.

particulars.

EXPERIMENTS IN RABIES PREVENTION.

It may interest readers to learn that some important experiments have recently been made in Southern India by Major Cornwell, I.M.S., and M. Keswa Pai. A virus emulsion of rabies has been exposed for several minutes to the action of cyllin, and injected into rabbits subdurally. The important observation has been made that it is possible, by means of cyllin, to destroy the virus of rabies in from three to five minutes at ordinary temperatures. The outcome of these experiments can hardly fail to be of much scientific interest.

hardly fail to be of much scientific interest.

B.A.M.C.—The term "tropical" is usually reserved for the amœboid form of dysentery, which is endemic in certain countries such as Hindustan, Cochin-China, Algiers, Egypt, and so on. One epidemic form is probably due to the rod-like hacillus, isolated by Shiga in Japan in 1838—the bacillus dysenteries. It is found in the mucous discharges from the outset, and Shiga himself claims to have remarkable results from an anti-dysenteric serum, especially if used at the beginning of an attack.

ning of an attack.

H. J. Rodner.—Yes, such a body is in existence. On June 26th, 1908, an Association of Subscribers to Charities was formed at the Mansion House, London. The avowed intention is to promote systematised co-operation between charities with kindred objects, the establishment of uniform principles and methods among charities in general, the promotion of facilities for interchange of information among charitiable institutions, and the strengthening of the financial position of charities which are endeavouring to carry out the objects of such an association. Hospital Reformer.—That part of our hospital system most urgently in need of reform is the out-patient department. The great drain upon finances thereby created is a serious tax upon the charitable, while at the same time a large amount of legitimate income is withdrawn from local general practitioners.

## Meetings of the Societies, Tectures, &c.

WEDNIEDAY, APRIL 21st.

WEDNIEDAY, APRIL 21st.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Berry: Olinique (Surgical.)

THURSDAY, APRIL 22ND.

HARVEIAN SOCIETY OF LONDON (Paddington Infirmary, Harrow Road, W.).—8.30 p.m.: Clinical Evening

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenics Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson Clinique: (Surgical).

FRIDAY, APRIL 23RD

ROTAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Fields, W.C.).—5 p.m.: Prof. Keith: On Specimens illustrating Malformations of the Face. (Museum Demonstration.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. G. French: Clinique (Ear, Nose, and Throat).

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. Abercrombie: Pharynx and Naso-pharynx.

#### Appointments.

BLOXSOME, ARTHUE H., L.R.C.P. and S.Edin., L.F.P.S.Glasg.,
House Surgeon to the Royal Alexandra Hospital for Sick
Children, Brighton.

DAVIES, J. L., Certifying Surgeon under the Factory and Workshop Act for the Newport District of the county of
Monmonth

DAVIES, J. L., Certifying Surgeon under shop Act for the Newport District of the county of Monmouth.

FIELDEN, W. E., M.D.Lond., Certifying Surgeon under the Factory and Workshop Act for the Staplehurst District of the county of Kent.

JOSCELYNE, A. E., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Taunton District of the county of Somerset.

Kerr, C. Lawson, M.B., Ch.B.Glasg., Assistant Medical Officer to the Argyll and Bute District Asylum, Lochgilphead.

#### Pacancies.

Kettering and District General Hospital.—Resident Medical Officer. Salary £100 per annum with board, residence, etc. Applications to J. Stanyon, Hon. Sec., 3, High Street,

Officer. Salary £100 per annum with board, residence, etc. Applications to J. Stanyon, Hon. Sec., 3, High Street, Kettering.

Torbay Hospital, Torquay.—House Surgeon. Salary £100 per annum, and an honorarium of £5 for the nurses' lectures, with residence and board. No stimulants provided. Applications to H. J. Packe, Secretary.

Colony of the Cape of Geod Hope.—Leprosy Research Salary, £450 per annum, with quarters and free rations on the Island. Applications to the Agent-General for the Cape of Geod Hope, 100, Victoria Street, London S.W

Caterham Asylum.—Third Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Caterham Asylum.—Caterham, Surrey.

Northumberland House, Finsbury Park, N.—Assistant Medical Officer. Salary £135 per annum. Applications to the Medical Superintendent.

Lincoln Mental Hospital, The Lawn, Lincoln.—Assistant Medical Officer. Salary £150 per annum, with board, etc. Applicacations to the Medical Superintendent.

Poplar and Stepney Sick Asylum District.—Third Assistant Medical Officer. Salary £120 per annum, with rations, turnished apartments, and washing. Applications to Frederick J. Morrison, Acting Clerk to the Managers, Clerk's Offices, Devons Road, Bromley-by-Bow, London, E

Staffordshire County Asylum, Cheddleton, Leek.—Temporary Assistant Medical Officer. Salary £200 per annum, with spartments, board, and washing. Applications to the Medical Superintendent.

Mercy Hospital, Cork.—House Surgeon Salary £50 per annum,

Superintendent.

Superintendent.

Mercy Hospital, Cork.—House Surgeon Salary £50 per anaum,
with board and apartments. Immediate application to Hon.
Sec. (See advt.)

#### Births.

BASSANO.—On April 14th, at Grove House, Ventner, I.W., the wife of Dr. Harold F. Bassano, of a son.
BIBD.—On April 15th, at Old Hayes, Sidmouth, the wife of Arthur C. Bird, M.R.C.S.Eng., L.R.C.P.Lond., of a daughter, Carmichael.—On April 15th, at 32 Rutland Square, Edinburgh, the wife of E. Scott Carmichael, F.R.C.S.B., of a son.
CROTTS.—On April 17th, at 26 King's Road, Windsor, the wife of A. Douglas Crofts, M.B.C.S., L.R.C.P.Lond., of a daughter.
FRENCH.—On April 12th, at "Rammore," Burgh Heath, Surrey, the wife of Ronald E. French, M.A., M.B., B.C., of a son.

#### Marriages.

LINDSET—CREAK.—On April 17th, at Emmanuel Church, Mannamead, Plymouth, Colin D. Lindsey, M.D., of Blandford, Mannamead, elder son of the late Assistant Commissary General J. L. Lindsey, to Isabel B. Creak, youngest daughter of Colonel Henry C. Creak, Bengal Cavairy (retired).

MKAN—CAMERON.—On April 13th, at St. Peter's Church, Cleathorpes, John Clarke Mead, M.B.B.S.Lond., F.R.C.S., only son of John and Emily Mead, of Watford, to Christina, second daughter of Alexander Cameron, M.D., and Mrs. Cameron, of Cleethorpes.

## Beaths.

BRUNTON.—On April 14th, at 10 Stratford Place, London, after a long illness, Louisn, the beloved wife of Sir Lauder Brunton, Bs., M.D., and daughter of the late Ven. E. A. Stopford, Archdeacon of Meath.

Fraer.—On April 15th, at 5 Tettenhall Road, Wolverhampton, John Fraser, M.D., aged 69 years.

Girmon.—On April 17th, at 39 Oxford Terrace, Hyde Park, Septimus Gibbon, B.A., M.B.Cantab., in his 84th year.

NUMN.—On April 13th, at The Gaunt Tower, Kneesworth, Boyston, from heart failure, after short illness, Thomas William Numa, F.R.C.S., of 27 York Terrace, London, Consulting Surgeon to the Middlesex Hospital.

TATIOR.—On April 15th, at his residence, Beechwood Hall, Mapperley, Nottingham, Charles Bell Taylor, M.D.Edin., F.R.C.S.E.

<u>Papapapapapapapapapapa</u>

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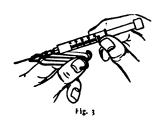


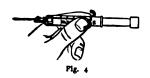
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## THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, APRIL 28, 1909.

No. 17.

#### Notes and COMMENTS.

Ventilation at the

MR. JUSTICE DARLING the other day corrected a barrister who spoke of the "New Bailey," pointing out that, Old Bailey. although a fresh and palatial building had taken the place of the old and

dismal Court where the last scene of so many sordid tragedies was enacted, historical continuity required that the place should still be known as the "Old Bailey." Without arguing the propriety of either designation, as to which much might be said, it seems that the architect and the City Committee responsible for the magnificent buildings, decided to keep to one evil tradition of the old Court, namely, that of insufferable ventilation. True, a system was designed, but it was a lamentable failure, and now air is left to find its way in and out of the courts at its own sweet will, which is as capricious as that of a maiden in love. Attention has been drawn to the defect time and time again, and only last week Mr. Justice Jelf and an alderman sitting with him had to complain of the excessive draught. Mr. Muir, the Treasury Counsel, replied that he had spoken of it so frequently that he was ashamed to do so any more, and the Judge finally said that if the matter were not attended to he would have to adjourn the Court-a very strong step. Now, it cannot but strike one as a most curious comment on the attitude of the public mind to hygiene, that where the Corporation are prepared to spend, and do spend, an enormous sum of money in erecting an enduring monument to the wealth and magnificence of the City in the shape of a criminal court-and a court where most of the parties are of the lowest and dirtiest class-that they should consider the question of health, as represented by the properties of air, as a kind of annoying minor detail which can afford to look after itself. The City Fathers are evidently more in touch with the insalubrious habits of their forbears than with the light of modern science.

Medical Congress.

THE forthcoming International Con-The Budapest gress of Medicine is now well within the scheme of practical politics. The sixteenth meeting—for the organisa-tion has now attained that critical

age-will be held at the beautiful city of Budapest, the capital of Hungary, opening formally in the banqueting hall of the municipality on Sunday, August 29th, and closing on September 4th. From detailed notices that have reached our office, it looks as if those responsible for the success of the meeting have taken time by the forelock, and have already drawn up a full and complete plan of cam-paign. Their activity—it may be remarked in passing-forms an agreeable contrast with the happy-go-lucky methods experienced at sundry

other congresses of no very remote date. One of the common-sense arrangements now announced is the possibility of securing rooms from the present moment, either in hotels or in apartments, by paying certain fixed prices in advance. In this way it is possible for intending visitors to form a fairly accurate estimate of expenses, and they have the further advantage of being able to choose accommodation at various prices which are accurately set forth under classes A, B and C. A small sum (8) kroner) is payable as a kind of registration fee by members who secure accommodation beforehand.

An Ideal Country. BUDAPEST is a city of entrancing beauty and interest, and so is the surrounding country. No less than six excursions have been arranged, extending from two to ten days, and

costing from 150 to 457 crowns, a sum roughly equivalent to £7 10s. and £22 17s. No. 5 on the list lasts from September 4th to 13th, and allows five days in Constantinople. The excursionists may return vid Trieste by putting into Athens and Corfu (at about £20 extra cost). No. 6 extends to Bosnia, Herzegovina, Dalmatia and the Hungarian Littoral, and lasts twelve days. A reduction of about one-half is made by most, if not all, the railways between Great Britain and Budapest, on production of membership ticket. The chance thus afforded of seeing many interesting and historical places is probably unique in the history of medical men of the United Kingdom. Those who wish to obtain more detailed information will find a full account on page 431 of our present issue. They will also be able to gather any further particulars by writing to the Honorary General Secretary for Great Britain, Mr. D'Arcy Power, 10A Chandos Street, Cavendish Square, London, W.

Mailed Fists. NOVELTIES in surgery, as recorded in current journalism, are a constant source of joy. The latest we have seen hails from Berlin, and is embalmed in the Manchester Dis-

patch. Professor Hoëftmann lately showed two patients at the Surgical Congress, who, we are interested to learn, had both lost hands and feet, and would in the usual way be considered to be permanently disabled from carrying on their occupations, which were manual. But the Professor would not allow their misfortunes to ruin their usefulness to society. Consequently, he has had metal extremities made to fit on to the stumps, and has so designed them in one case that the patient, a locksmith, is able to carry on his handi-craft with perfect ease. It seems that his tools fit, "by a simple system requiring no outside aid," into the metal end of his stump, and he is able to follow his trade as well as ever. this be described, as in the headline, as a "miracle of surgery," though when we come to think of it, we are not sure if the manufacture of iron hands and mailed fists is part of surgery proper. In British text-books at least the question is severely tabooed. Without further inquiring how the patients get along without feet, we feel we may now safely conclude that surgery-like love-laughs at locksmiths.

Vet Another Accident.

ONE thing the Workmen's Compensation Act has done, if nothing else, is to enrich the meaning of English words, for the decisions of judges in

contested cases have gone from one her, till at present an "accident" point to another, till at present an appears to mean anything one does not like. At Marylebone County Court, last week, a workman claimed against the Kensington Borough Council on the ground that he was suffering from gangrene, the result of frost-bite. He stated that he was engaged on December 20th last for sixteen hours in distributing salt in the streets in connection with operations for clearing away snow. His feet became painful, and on consulting a doctor soon afterwards he was told he was suffering from frost-bite. Medical evidence from St. George's Hospital confirmed the fact, and his counsel contended that as the occurrence which gave rise to the injury was unintended and unexpected, and produced loss, it came within the meaning of the The Judge agreed with this view, and While granted the applicant his compensation. sympathising with the workman in this case, it is difficult in the extreme to see how a disease resulting from prolonged exposure to cold, and probably from the patient's previous bad health, can in any sense of the word be termed an accident. To hold such a view is to throw medical terminology and indeed the whole English tongue into the melting-

#### LEADING ARTICLES.

THE RESEARCH DEFENCE SOCIETY.—No. I.

THE publication in book form of certain selected articles and views by the Research Defence Society marks an important step in the collective defence of scientific medicine. The movement is still in its infancy, for the body in question was founded so recently as January 27th, 1908, but the small volume before us forms a complete vindication of the avowed objects of the Society, namely, "to make known the facts as to experiments on animals in this country, the immense importance to the welfare of mankind of such experiments, and the great saving of life and health directly attributable to them." (a) We propose to take a few salient points from some of these communications, with the view of showing the direct practical value to mankind of experimental research, as an assertion to the contrary is one of the stock weapons of the anti-vivisectionist. One of the most suggestive articles is one dealing with the experimental study of the action of drugs by Professor Cushny,

F.R.S., of University College, London. At the outset he quotes a remarkable instance of the failure of clinical methods to determine the precise action of a given drug. Digitalis was introduced by an English physician-Withering-and became widely used as a remedy. In 1860, however, seventy-five years after its introduction, a writer on therapeutics stated that digitalis slowed and weakened the heart, and should therefore be administered in aneurysm, apoplexy and acute fever. A few years later that drug was shown experimentally by Traube and Brunton to raise the blood-pressure to a marked extent, and its use was absolutely contraindicated in aneurysm and apoplexy, while in pneumonia and fevers it was restricted to cases in which the heart became Used in cases of pneumonia without affected. heart complications, digitalis would probably do more harm than good. The precise therapeutic value and appropriateness of this valuable remedy were ascertained solely by experimental methods. In a similar way an immense expansion of the resources of the therapeutist has taken place. As a matter of fact, a large number of new remedies. have been discovered quite accidentally in the course of investigations which have had no direct therapeutic object in view. Chloral furnishes a case in point. Chloral was found by Liebig in 1832, but was not used medicinally for thirty-six years, until Liebreich discovered its soporific action by experiments conducted for the investigation of a problem of purely scientific interest, namely, whether "a substance is broken up into its constituent parts before it is oxidised." Dr. Cushny remarks that no soporific has been introduced in the last forty years, except by means of animal experiment, and, further, that no local anæsthetic has been discovered by other methods. Let the opponents of experimental research try and realise the enormous amount of human suffering that has been daily averted by the introduction of cocaine, to take a single one of the long list of drugs included under the heading of local anæsthetics. A similar proposition can be put forth with regard to vascular dilators and vascular contractors, all of which owe their origin to experimentation. Among other substances similarly introduced may be mentioned lysol, apomorphine, ethyl chloride, and thyroid gland, Indeed, Dr. Cushny is able to mention only one drug of even mediocre importance that has been brought into use by other methods during the past forty years, "during which the experimental method has been so fruitful in valuable remedies. The exception is pilocarpine, which was introduced in 1874 from its being used in South America as a sudorific." Another convincing article is that by Mr. Louis Courtauld on the value of antitoxin in the treatment of diphtheria. There is hardly any one subject upon which the opponents of experiments upon the lower animals are more positive and vehement than that of the failure of antitoxin treatment to lessen the loss of life from diphtheria. As our readers know, the matter has to be carefully examined to eliminate the fallacies. The frequent assertion, for instance, that, on the whole, diphtheria has risen rather than fallen since the introduction of antitoxin, is fallacious by reason of the epidemic waves to which

<sup>(</sup>a) "Publications of the Research Defence Society, 1908-1909." Macmillan.

the disease is subject, the former separation of croup from diphtheria, the recognition of latent cases of diphtheria, the fact that the Registrar-General's mortality figures are the main source of information, and the modern possibility Where the case-mortality accurate diagnosis. is ascertained, together with an exact diagnosis, and the number of patients treated with antitoxin noted, a reduction in fatal cases, roughly speaking, of one-third has been recorded. In the Metropolitan Asylums Board hospitals the mortality fell from 28.5 per cent. in 1880-1890 to 8.3 in 1908, in New York from 36.7 in 1891 to 13 in 1899, and in Paris from 45 in 1893 to 14.5 in 1898. Positive results of this kind form an argument unanswerable by any logical process of reasoning. There is so much matter of interest in the rest of the Research Defence Society's little book that we propose referring to it in a second article at an early date. Meanwhile, the energetic Secretary, Mr. Stephen Paget, may be congratulated upon the fact that the membership of the Society now extends to the handsome total of 2,250 names.

### THE CAUSE OF POST-OPERATIVE TETANUS.

THE subject of post-operative tetanus has been brought prominently before the medical profession by two communications, one which was read before a medical society in Dublin by Dr. L. G. Gunn, and the other which appears in the British Medical Journal, by Dr. W. G. Richardson, of Newcastle-on-Tyne. Both writers were led to discuss the subject by the unfortunate fact that they had met, or had had their attention drawn to, cases of post-operative tetanus, and both writers make an earnest and important attempt to elucidate the mystery which always surrounds such cases. It is unfortunately the fashion to attribute post-operative tetanus to infection received from catgut. train of arguments which leads to such a belief is, at first sight, so rational that broken links are overlooked, and its acceptance has been so general that other possible explanations have shared a similar The writers mentioned are, therefore, especially to be commended, because they have not allowed their investigations to be hampered by pre-conceived ideas. Though neither of them are in a position at the end of their investigations to formulate definite conclusions, they both are able to Both recognise the bring forward suggestions. extreme difficulty of imagining that catgut can give rise to a small epidemic of cases in particular localities, while places outside these localities are entirely unaffected, although they receive catgut from the same general source and use practically identical methods of sterilisation. Dr. Gunn's investigations, made in a hospital in which three cases followed one another at short intervals, resulted in the finding of a water supply which might, or might not, be contaminated, and which certainly offered opportunities of contamination. Assuming that air-borne tetanus germs had reached it, it also offered a convenient mode of distribution. Dr. Richardson goes further afield for his explanation. In the first place, he calls attention to three points of considerable interest. The first point is that 90 per cent. of the operations in which postoperative tetanus occurred involved the peritoneal cavity. The second point is that there is a disease amongst sheep known as "louping-ill," whose similarity to tetanus is very marked. The late Professor Hamilton was the first to call attention to this disease in a paper entitled "The Alimentary Canal as a Source of Infection," and he suggests that "idiopathic tetanus" may be a disease produced by the same class of organism as that producing "louping-ill." Dr. Richardson's third point is that the geographical distribution of "loupingill," as defined by Professor Hamilton, and of the cases of post-operative tetanus which he has collected, is almost identical. In this connection, it is of importance to note the actual facts. Professor Hamilton speaks of the valley of the North Tyne as "one of the most severely-smitten areas" in the case of "louping-ill," and Dr. Richardson finds that of his twenty-one collected cases of tetanus eleven occurred in Northumberland. He therefore suggests that the disease which we call post-operative tetanus is not tetanus at all, but one of the sheep diseases; that it is not introduced by catgut; that the patient at the time of the operation is the host of the bacillus, and that we must look on cases of post-operative tetanus as cases of "idiopathic tetanus," accepting Professor Hamilton's suggestion that "idiopathic" is not "true" tetanus. The suggestions made by Drs. Gunn and Richardson are in a great sense speculative, and it is impossible to say whether it will be possible to substantiate the one or the other. However that may be, by drawing our attention away from a supposition which time and repetition has converted into a "fact," they have done a most praiseworthy and necessary work.

#### CURRENT TOPICS.

#### Infantile Mortality in Workhouses.

THE Minority Report of the Poor-law Commission drew public attention to the remarkable fact that the mortality among infants born in Poor-law institutions was two or three times as great as that among those born to the general population. Certainly this state of affairs called for investigation, as we have a right to assume that workhouses, even if not ideal nurseries, are at least maintained in a condition as sanitary as the homes of the poor. The Local Government Board have investigated the subject, and, in consequence, have just issued a Memorandum setting forth the facts they have elucidated. In the first place, considerable fault is found with the figures supplied to the Commission on the ground of inadequacy, and they deprecate the "definite and sweeping conclusions" of the Minority Commissioners based on these premisses. Still, the mortality is too high to be explained by merely inadequate figures, and the chief point on which the Board rely in their apologia is on the general type and character of the parents. The proportion of illegitimate births in workhouses is enormously high. The metropolitan workhouses give a proportion of 60 per cent., while that for the general population of London is 3.75 per cent. The wretched mothers, and hardly less wretched fathers, frequently suffering from syphilis, are hardly of

the type to produce healthy offspring, and when this consideration is taken into account, with the further fact that about half the children leave the institution within three weeks of birth, it is obvious that the excess of deaths falling within this period points rather to pre-natal conditions and physical debility or disease than to want of care during the first year. Now, of 312 children who died in metropolitan workhouses, no less than 112 died in the first week of life, a death-rate of 42.2 per thousand! In the second week the rate fell to 6.1 per cent., which is actually a trifle lower than that of infants born to the general population. These considerations, while pointing to a somewhat excessive zeal on the part of the Minority Commissioners, also teach the lesson that paternal culture -if one may use the expression-is of supreme importance in raising human stock.

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Disease and History.

In a recently-published book by Mr. W. H. S. Jones and Dr. E. T. Withington, a most interesting argument is adduced to account for the contrast between the poor and mentally-feeble population of modern Greece and the virile, intellectual people who created the most wonderful literature, art and philosophy in the history of the world. The theory, in brief, is that malaria was introduced into the country and created such ravages that the population of the valleys and lowlying districts were not only decimated and held in numerical check, but that their ancient moral and physical energy were swept away. Such a theory would certainly account as nothing else would for the extraordinary change which has admittedly taken place, but, fascinating as it is, no particular weight must be assigned to it without some historical evidence in its favour. Naturally this is very difficult to procure, as the invasion of malaria would be insidious rather than dramatic, and, not being recognised clinically, would fail to catch the eye of writers. Mr. Jones and Mr. Withington have nevertheless made the most of the material at their disposal, and have presented a very plausible case for consideration. Such an innovation in the treatment of the facts of history was certain to find much criticism at the hands of the orthodox school of historians, to whom battles and political changes make up most of the substance of their science, and criticism has not been spared. Professor Ronald Ross has gallantly stepped into the arena, and in a letter to the Literary Supplement to the Times, he draws an interesting parallel between Greece (if the theory be true) and Mauritius, showing how that island, from being nearly a heaven on earth, was in 1865-7 turned by the introduction of malaria into a poor, sparsely-populated, unhealthy country. In Greece, as in Mauritius, the valleys would be the places to suffer, and the well-to-do would retire to the high lands to live, with the consequence that agriculture and trade would be paralysed. The argument would not affect large places like Italy, where the natural features are so widely varied, and where malaria would be chiefly confined to swampy districts, unlike Greece, which consists chiefly of mountain and valley. So many new lights have been admitted to shine into history in the last half-

century, that we trust this attempt of Mr. Jones and Dr. Withington will establish the right of pathology to count as a factor in the influences which make and mar empires.

#### Anti-Vivisectionist Falsehoods.

At the recent annual meeting of the supporters of the Meath Hosptal, Dublin, Sir John Moore, the senior visiting physician, gave an emphatic denial to a statement which had been circulated to the effect that vivisection has been practised at the hospital, and said that it was a deliberate and unfounded falsehood. It is a poor heart that never rejoices, and Mr. Stephen Coleridge has taken advantage of Sir John Moore's indignant denial of an antivivisectionist falsehood to write to the papers and point out how "in Dublin they seem to know well enough that the financial supporters of hospitals for the sick poor are drawn from the tenderhearted, sympathetic, deeply moral sections of the community, to whom vivisection is an immoral, disgusting, and degrading practice. They admit that the mere rumour that the Dublin hospitals are in some way associated with the odious thing is sufficient to check the flow of subscriptions; and they are fortunately untramelled by the august influences which, some of us deplore to observe, are in London being more and more extended to the patronage of vivisection." One would have thought that Mr. Coleridge would have been unwilling thus to draw public attention to the fact that a falsehood had been promulgated in support of the cause he advocates, and especially that he would not have tried to gain a trifling point by its aid. It may be a source of dissatisfaction to him to learn that, although at the time the falsehood was promulgated there was in Dublin a certain proportion of people which had never taken the trouble to probe the true inwardness of the antivivisection movement, and who gave it some supvivisection movement, and which gave it some supdiminished. The deliberate and uncalled-for attack on the Dublin hospitals drew attention to antivivisectionist methods, and the foundation of the Dublin branch of the Research Defence Society removed a cloud of misconception which had merely resulted from ignorance of the necessities and value of scientific research.

#### One Day in Seven.

In the rush and hurry of modern life, the twentieth-century man is apt to lose sight of the wisdom of the ancients with regard to the proper guidance of life. One of the soundest of these ancestral laws is that which devotes six days to labour and the seventh to rest, as set forth in the Hebraic Code. A good deal depends on the exact meaning attached to the definition of the word "rest," and it is clear that what is rest to one man may spell quite another thing to his neighbour. The sedentary man wants golf or something that gives him fresh air and exercise in keeping with his time of life, while the active man who works with body or brain requires rest in hammock or armchair or other lounging attitude in the best air obtainable. Apollo cannot always stretch the bow. nor can the most physically perfect of our men and women always live at high tension. Sooner

or later the busiest have the lesson brought home to them of the absolute need of a rhythmic change of occupation, and that one day of rest in seven is requisite to keep the human machinery in first-rate working order. If the bodily engine be not used sufficiently it rusts; if it be worked without cessation it wears out prematurely. Viewed in this light the week-end out of town for the wealthy, and the Saturday half-holiday and Sunday rest for the worker, are the wisest and best safeguards for the conservation of the national efficiency at its highest standard. Therefore, now and then idleness is not an unpardonable sin. Verbum sap.

#### The Medical Register for 1909.

THE appearance of the Medical Register for 1909 is an event of sufficient importance in the medical world to demand a passing notice in the columns of a professional journal. The accuracy of much of the information contained in its introductory pages renders this volume of value as a book of reference. The abstract of the Medical Acts from 1858 to 1905, for instance, should be useful at times to any and every medical practitioner. One point of permanent interest is the annual increment of numbers of medical men on the Register, which, of course, does not represent the total number of qualified men, as many of the latter have never taken the necessary steps to have their names placed upon the official Register of the General Medical Council. The number on the Register at the end of 1908 was 40,257, or an increase of 1,430 on the preceding year; these figures show an increase over the average of the last five years. and a much larger increase over that of the past quarter of a century. There is a formidable list of twenty-six corporate bodies entitled to grant registrable qualifications, a fact that may well give pause to the most ardent "one-portal" reformer when he realises the magnitude of the interests he is seeking to consolidate and unify. This year the size of the Register is slightly, but still appreciably, increased, a fact which is fully accounted for by the additional matter entailed by fresh names and more extended official information.

#### Camping-Out as a Curative Measure.

Many of the maladies of modern civilisation undoubtedly spring from lack of fresh air and regular exercise, with an intake of food and drink in excess of the bodily requirements. For all com-plaints of that class the "simple life"—as it is called -is not only a perfectly logical, but, as a rule, a successful method of treatment. In strenuous America-where it is rarely the fashion to do things by halves-camping-out has come into great vogue. The outfit of the camp for sleeping, cooking and other needs of elemental life have been reduced by the ingenious storekeeper to the level of a fine art. Should it be elected to travel along a river, the boat can be covered in at night, or, more commonly, a tent is pitched on shore. Sometimes the whole camp outfit is carried on mules or ponies. In any case, the life in the open, with its accompaniments of pure air, exercise, plain food and early hours, is calculated to bring a fresh lease of life to the jaded dweller in crowded towns. There is no particular reason why camping-out should not be extensively practised during the summer months in the United Kingdom. The cost of a plain tent outfit would in most instances be more than covered by the week's rent payable for cramped lodgings at any popular seaside resort in the holiday season. If that will-o'-the-wisp, a return to the simple life, be a desirable thing—and few medical men would argue to the contrary—then camping-out is surely one of the most logical, as it is the most available, of all our civilised essays in that direction. Those who have lived once on a camping-out expedition appear never to want a better holiday—a fact that speaks volumes in its favour.

#### PERSONAL.

THE KING has been graciously pleased to confer the new Territorial decoration on Surgeon-Lieut.-Colonel J. D. Lloyd, of Chirk, North Wales, who has been attached to the Shropshire Yeomanry for thirty years.

FIELD-MARSHAL LORD GRENFELL, P.C., G.C.B., will take the chair at a Festival Dinner in aid of the East London Hospital for Children, Shadwell, which will be held at the Ritz Hotel to-night.

THE LORD MAYOR OF LONDON will preside at the Festival Dinner of the Royal Hospital for Incurables, Putney Heath, on May 5th, at the Savoy Hotel.

THE Festival Dinner of the City of London Lyingin Hospital will be held at the Trocadero Restaurant on April 29th. The Hon. Rupert Guinness, C.M.G., M.P., will take the chair.

THE Government have granted £200 to Mr. Harry W. Cox, manufacturer of X-ray apparatus, on account of his sufferings through the use of Röntgen-ray, apparatus.

THE LORD MAYOR OF LONDON will preside at a Festival Dinner in aid of the funds of the City of London Hospital for Diseases of the Chest, to be held at the Trocadero Restaurant on May 6th.

DR. T. SHADICK HIGGINS has been appointed Assistant Medical Officer of Health for Birmingham, in the place of Dr. Buchan.

DR. THOMAS CRAIG STEVENSON, Medical Officer of the Education Committee of the Somerset County Council, has been appointed Superintendent of Statistics of the General Register Office, Somerset House.

DR. T. A. SELLAR, of Aberlour, was last week presented with a handsome motor-car, subscribed for by patients and friends, in recognition of his services as a medical practitioner and of the esteem in which he is held in the district.

At a meeting of Convocation of the Royal University of Ireland, Dr. Campbell was elected representative of Convocation on the Senate of the University by 272 votes, as against 94 votes cast for Dr. Magennis, of Dublin.

### A CLINICAL LECTURE

ON

#### RENAL CALCULUS.

By ANDREW FULLERTON, M.D., F.R.C.S.,

Honorary Assistant Surgeon to the Poyal Victoria Hospital, Belfast, and to the Belfast Hospital for Sick Children.

(Concluded from page 398.)

PART II.

Diagnosis.-Although the symptoms which have been described will raise strong suspicions of a renal calculus, the patient must be examined by all the modern methods, to confirm or correct our diagnosis. It not unfrequently happens that a patient supposed to be suffering from a renal calculus is, in reality, the subject of gall-stones, duodenal ulcer, appendicitis, colitis, or some other complaint. The family and colitis, or some other complaint. The family and personal history of the patient may afford valuable assistance. The history of gout, or the passage of sand or gravel is of importance. The history of pain increased by exertion, the occurrence of typical attacks of colic, &c., will direct our attention to the urinary organs. A careful physical examination must now be made. It should be berne in mind that the painful kidney may actually be the sound one. Pressure on the affected organ may be associated with severe pain but on the other hand may afford no severe pain, but, on the other hand, may afford no assistance. I recently examined a patient in whom pressure on the affected kidney produced pain on the opposite side. Strong percussion in the lumbar region will in some instances produce severe pain, but it may as frequently fail. If retention or suppuration has occurred, the organ may be felt to be enlarged, and the stone or stones may even be palpable. In many cases, however, palpation and percussion will fail to enable us to come to a diagnosis. The urine must now be examined for blood, pus, casts, crystals, fragments of tumours, parasites, tubercle bacilli, and other abnormal constituents. I have already indicated how the cystoscope may be a valuable aid to diagnosis, and, in this connection, I might refer to the assistance which the ureteral catheter or probe coated with wax, or tipped with metal, may afford in some cases. Mr. Newman, of Glasgow, has devised an instrument for this purpose which he calls a resonator. [A short description of it is given in The MEDICAL PRESS AND CIRCULAR of May 6th, 1908]. Used in the ordinary way, the cystoscope is one of the most valuable means at our disposal for the diagnosis of kidney troubles. Pyuria and hæmaturia can be traced to their source with the greatest certainty, and the presence or absence of bladder complications can be accurately ascertained. When it is remembered that renal calculus may give rise to symptoms similar to an attack of acute cystitis, it will be evident that a careful inspection of the interior of the bladder ought not to be neglected. Again, before operating on a kidney which may, on exposure, prove to be so dis-organised as to require removal, it is, to say the least of it, comforting to know that there is a second kidney, and that it is capable of carrying on the renal functions. This can only be satisfactorily ascertained by previous cystoscopic examination, and catheterisation of the ureters, or by chromocystoscopy, that is, ascertaining the power of each kidney to excrete coloured substances, such as methylene blue, or sulphindigotate of soda. Cryoscopy, or the phlorizin test, may also be used alone or in addition to the colour tests, but it is advisable in all cases to use the ureteral catheter. Of course, the various segregators may be used, but one cannot inspect the interior of the bladder with these instruments, and one valuable means of diagnosis is lost. I have used the catheterising cystoscope in this way more than a hundred times without any serious result following, and I can recommend it to a careful operator as a safe, satisfactory, and expeditious method of ascertaining the condition of the kidneys.

The use of the X-rays is hardly less important, and a positive result is a great help to the surgeon. The presence of a shadow shaped like a calculus in the proper region is strong presumptive evidence of the presence of such, but is by no means conclusive, as other objects, such as calcareous lymphatic glands, phleboliths, fruit stones, fæcal material, atheromatous patches in arteries, &c., may give similar appearances. Mistakes of this kind are reduced to a minimum by the method, suggested by Mr. Hurry Fenwick, of passing an opaque ureteral bougie and noting the repassing an opaque ureteral bought and noting the least of the shadow or shadows to the line of the ureters. I have used ordinary ureteral catheters charged with fuse wire for this purpose, and have found that they show up exceedingly well in the photo. Of the various kinds of calculi usually found, it appears that the oxalates give the sharpest shadow. Next to these come those composed of uric acid or urates, while soft phosphatic stones are not so easily seen. This branch of radiography has recently been brought to such perfection that if the suspected stone is not visible in the X-ray photograph, some other cause will probably be found for the patient's symptoms. This work requires good apparatus and a skilful radiographer, and can only be satisfactorily

carried out in large centres.

Treatment.-Many attempts have been made to dissolve renal calculi, but though some evidence has been brought forward to prove that this may have been accomplished in a few isolated instances, most surgeons would consider it waste of time to trust to such a fortunate occurrence. At the same time, it is quite scientific to attempt to rectify any abnormality in the urine, such as excessive acidity or alkalinity, by appropriate remedies. If the urine is septic, it is a wise precaution to use urotropin dissolved in large quantities of water. This drug, besides acting as an antiseptic, is believed by some well-known urologists to exert a solvent action on calculi composed of urates or uric acid. Moreover, it is said to act beneficially in cases of phosphaturia. Large draughts of boiled water, or the various mineral waters recommended for this purpose, will be beneficial in diluting the urine and washing out small particles already formed. A question which it is a little difficult to answer is whether it is advisable to operate in all cases of ascertained renal calculi. It cannot be denied that an aseptic calculus may remain quiescent for years, or give rise to symptoms so infrequently as to cause the patient such slight inconvenience that he hesitates to subject himself to what must be admitted is a somewhat severe operation. Again, a small calculus may pass and leave the patient quite well. The patient must be given clearly to understand, however, that a calculus which is to-day aseptic may at any time become a source of danger, not only to the affected kidney, but also to the life of the patient, by the advent of sepsis, or by becoming impacted in the ureter. Besides, one cannot say with certainty, how much damage and degeneration may be occurring to the life of the patient. in a kidney the seat of even a small aseptic calculus. In the hands of a capable and experienced surgeon the risks of operation are so slight, that it is advisable to remove a calculus known to be present, if there is

no contraindication to the operation on other grounds, and this ought to be done when the patient is in the most favourable condition to undergo the ordeal, rather than at a time of great stress, when it has become a source of danger to him. It is quite likely that the patient, or his medical attendant, may not consent to this being done, and the operating surgeon must then content himself with pointing out the risks which the patient runs of a serious hæmorrhage, the onset of sepsis, or the occurrence of hydro- or pyonephrosis. Another class of cases will require consideration, those in which the operation will be of the nature of an exploration. We have all operated for renal pain or hæmorrhage or persistent pyuria, and have failed to find the expected stone. The risks of this unsatisfactory ending must be explained to the patient, so that no undeserved blame may be laid at the door of the surgeon, who has presumably done his best for his patient. If some other condition is found and relieved, the operation has been justified; if not, no great harm has been done. I can call to mind several cases of painless hæmaturia which were cured by the operation, though no lesion was discovered. With the aid of the X-rays such fruitless operations will become much less frequent in the future.

In contradistinction to the class of cases just discussed, there is a class in which operation is imperative—that in which anuria has occurred. If complete anuria is present, the patient will probably die if not relieved by operation. The anuria may be due to both ureters being blocked, and in this case, no time must be lost to free at least one kidney, taking care to select for attack the more efficient of the two, if it is possible to determine that point. If not, I see no reason why both kidneys should not be operated on, if the one first inspected seems incapable of carrying on the renal functions. Even an incision into the kidney will permit the escape of the pent-up urine, and save the patient's life. In cases of reflex anuria in which one kidney contains a stone, or in which a stone in the other kidney is not causing the obstruction, an attack must be made upon the side of the obstruction. This may be very difficult to determine. The previous history, the appearance of the ureteral meatus, and careful physical examination of the patient, may help to decide the point, but in any case, something must be done, and it is safer to explore both kidneys than to allow the patient to die while trying to make up one's mind which side to attack. It will also be necessary to operate in cases of acute septic infection occurring in the calculous kidney. At least an incision must be made into the affected kidney, and the sound one thus saved if possible. With the cystoscope, the proper side to attack can be determined with absolute certainty. Further proceedings may be decided on at a later date, when the severity of the attack has passed off, and the patient is able to stand the shock of a more prolonged operation. The presence of a calculus completely obstructing the ureter is an indication for immediate interference, first, to obviate the risks of serious, if not irreparable damage to the affected organ, and, secondly to obviate the supervention of sepsis and the conversion of a hydronephrosis into a pyonephrosis. In pyonephritis, operation must be undertaken without delay. In cases of severe hæmorrhage, operation is indicated before the patient is anæmic and exhausted by repeated attacks. Recurring attacks of severe pain will lead most patients to seek relief by any means, and it is not difficult to persuade a patient who has suffered the agonies of frequently repeated attacks of renal colic to submit to operation. Taking everything into consideration, therefore, it may be stated that a patient with a renal calculus is not in a safe condition, and that there are certain complications, such as anuria, obstruction, sepsis, hæmorrhage, and severe pain, that demand operative interference. Taken all round the mortality of operations for the relief of renal calculus does not, at the present day, exceed 5 per cent.

Operation.—The removal of a renal calculus having been decided on, it is now necessary to discuss, very shortly, the procedures which it is advisable to adopt. Most surgeons are now agreed that the lumbar incision is the best, for many reasons, to adopt. The kidney having been well exposed and brought out on to the loin, the pelvis may first be palpated, when, in many cases, the calculus will be found. This may be removed by incising the kidney, or cutting down directly on the stone through the pelvis, a method which has become more popular in recent years. In this way a good deal of damage to the kidney is avoided, and ecent results have shown that this wound heals quite kindly. It must be admitted, however, that it is more difficult to remove large stones in this way, and that there is a danger of overlooking stones in the kidney itself. For this reason, many surgeons prefer to incise the kidney through the convex border, right into the pelvis. In this way a very accurate examination, not only of the kidney, but also of the pelvis and calyces, can be made, and, if necessary, a catheter can be paseed into the bladder from the wound in the kidney, with, I think, greater ease, than through an opening in the pelvis. I prefer myself, so far as my present experience teaches me, to make my incision through the kidney itself. I have ascertained that the organ, even after very free incision, will perform its functions in a satisfactory way, as seen by examination with the catheterising cystoscope, even before the patient leaves the hospital, and the wound in the kidney seems to heal with the greatest rapidity. Clean-cut incisions into the kidney may be sutured with catgut, but wounds lacerated and contused by dragging a large calculus through, should be left at least partially open, any hæmorrhage being arrested before the kidney is replaced. If no stone has been discovered by the means already adopted, the ureter should be palpated as far towards the bladder as possible, the wound being enlarged, if necessary. If a stone is found far down the ureter it may be cut down upon in situ, or, preferably, it may be pushed up into the pelvis of the kidney, and so removed. In all cases, the patency of the ureter should be ensured by the passage of a long bougie or ureteral catheter. In this way, as in the case I mentioned earlier in this lecture, a stone may be dis-lodged, and an abortive operation converted into a highly successful one. If the stone is pushed into the bladder, it may be removed by the evacuator, or by crushing. In one of my cases it was passed by the urethra, after what appeared to have been an unsuccessful operation. A stone far down, beyond reach through the lumbar incision, may require removal through an incision similar to that used for ligature of the common or external iliac arteries. If projecting into the bladder, it will require removal through that viscus. Incisions into the ureters may, in accessible situations, be sutured, if the ureter is healthy, care being taken not to unduly narrow the tube. If inaccessible, or if the ureter is not healthy, they must be freely drained. In a few rare cases, it may be necessary to remove the kidney. In one of my cases, the stone had ulcerated almost through the ureter at its upper part, and there were numerous small abscesses in the thinned cortex of a pyonephrotic kidney, so that I was obliged to remove the organ. A good deal will depend on the condition of the kidney as regards the amount and character of the parenchyma left, and upon the efficiency of the other kidney. If the organ is extensively disorganised, it will only prove a source of danger, and ought to be removed, if the other kidney has been found to be efficient. If there is any doubt on the latter point, palliative measures must be adopted. After incision and drainage, it is surprising how much recovery may take place, and the individual experience of the operator will guide him as to how far to trust to conservative measures. If it becomes necessary to perform secondary nephrectomy, the difficulties are much increased by the scar tissue which will have resulted from the former operation.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by William Alexander, M.D., F.R.C.S., Hon. Surgeon, Boyal Southern Hospital, Liverpool; Lecturer on Clinical Surgery, Liverpool University. Subject: "On the Direct or Indirect Effects of Surgery or Surgical Lesions on Mental or Nerve Disturbances."

#### ORIGINAL PAPERS.

#### NOTES ON CASES. (a)

By T. CARWARDINE, M.S.,

Surgeon, Bristol Boyal Infirmary,

GALL-STONES IN GALL-BLADER, CYSTIC DUCT, COMMON DUCT, AND HEPATIC DUCTS, IN A GIRL OF SEVENTEEN.

This case is noteworthy from the youthful age of the patient, and the extent of involvement of the biliary apparatus.

She had indigestion two years previously, independent of food. Three months ago she had pain across the stomach and back, chiefly on the left side, and jaundice appeared when the pain ceased. A short time ago she had return of severe pain beginning and ceasing suddenly, lasting several days, and followed by jaundice. Thus she had two attacks of pain recently, in the first of which the urine was dark and the motion light.

When admitted she had a little jaundice and

no other symptoms.

At the operation there were adhesions about the gall-bladder, which was surrounded by jellylike lymph. (Fig. 1.) The liver was large and congested; and the gall-bladder, of yellowish colour, contained a milky fluid, stones and sand. On exposure of the ducts they were all found to be hard from contained stones. An incision was made into the common duct, where there was a large stone, and it was extended up into the cystic and common hepatic ducts, which were full of stones and grit. After these were cleared out more débris were found in the right and left hepatic ducts, which were also cleared. The pancreas was hard. Adequate drainage was provided, and the patient made a perfect recovery, leaving three weeks after operation.

STONE IN COMMON BILE DUCT WEIGHING 11 0Z., AND MEASURING 31 INCHES LONG AND 4 INCHES IN CIRCUMFERENCE.

This is an example of an enormous gall-stone removed from the common duct during life; although there is recorded an example of a larger stone, which weighed nearly  $3\frac{1}{2}$  oz., removed from a patient after death. In the latter case there is evidence that bile passed into the duodenum, for it is recorded that fluid bile surrounded the stone; and in my case, although the stone was so large, and its lower end fitted like a ballvalve into the dilated ampulla of Vater, the patient was not deeply jaundiced.

She was a woman, æt. 64, who had been subject to bilious colic for 37 years, and on two occasions gall-stones had been found in the stools. She was admitted a week after a bad attack of colic with rigors and sickness; the jaundice cleared up but again increased, and a hard resistant mass could be felt below the right hypochondrium, below which the lower border of the liver could be felt some few inches.

(a) Shown at the meeting of the Bath and Bristol Branch of the British Medical Association, October 28th.

When the abdomen was opened a very hard mass presented itself in the common duct, which gave a ringing sound when percussed with a pair of forceps. The gall-bladder was very small, and contained a solitary calculus surrounded by a little turbid fluid, and the cystic duct was occluded. (Fig. 2.) The large stone in the common duct was removed by extending the incision until it could be delivered. The finger was then passed into the much-dilated hepatic ducts above and the duodenum below. The wound in the common duct was sutured in part, and drainage provided. At first she was troubled with some sickness, and was reported to have had a kind of fit on four occasions during the first eighteen hours, each fit lasting from two to seven minutes—the jaw was fixed, the hands twitching, the eyes staring, there was no response to questions, and no change of colour. The patient made a satisfactory recovery, without pyrexia, and she is now well.

PANCREATIC CYST IN A BOY, AGED SEVEN.

The patient was a thin boy, who fell off his bicycle and struck the abdomen against the handle bar. He was seen two hours afterwards. when a slight contusion over the left hypochondrium was observed, and he complained of abdominal pain and tenderness in the epigastrium. There was little shock and no rigidity of the abdomen. The pain continued next day, and every ten or fifteen minutes there were severe colicky exacerbations. For the three days following the accident his temperature was 100 deg. to 101 deg., and he was frequently sick.

Five days after the accident a rapidly increasing swelling could be felt in the epigastrium, and the lower edge was clearly defined at first. Later the pain and swelling increased till the latter reached to three inches below the umbilicus, and occupied the whole of the right side of the abdomen, and the patient lost flesh considerably. Three weeks after the accident he had vomiting with a considerable increase in the size of the swelling. A month after the accident, I operated in the right semilunar line, when about three pints of clear yellowish fluid were withdrawn from a cyst, the wall of which was about one-eighth inch

thick and friable. (Fig. 3.)

The fluid was tested by Dr. Walker Hall, who gave the following report:—

S.G.—1008; alkaline.

Albumin—5 parts per 1,000 Esbach. Fat-Large traces in ether extract.

Deposit—Numerous cells containing fat droplets. Small amount of pigment, cholesterin and calcium crystals.

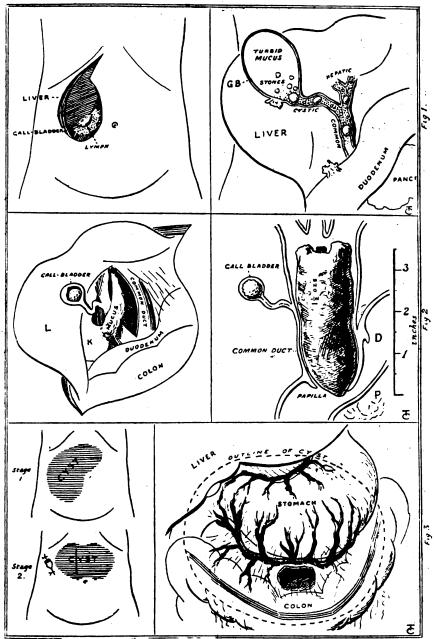
Digestive Action.—After forty-eight hours there is distinct evidence of the digestion of protein. (Trypsin therefore present.)

Reducing Substance .-- There is present a reducing substance which is not sugar.

After the operation very little more fluid escaped. and four days afterwards a swelling appeared in the epigastrium, rapidly increasing in size, and pushing the original drainage-tube downwards and outwards in the right loin. The colicky pains returned and the patient looked much worse. A second operation was, therefore, performed, six days after the first, through the right rectus muscle. The stomach was immediately below the incision, and adhesions to the parietes were separated. An opening through the gastro-

colic omentum revealed a tense cyst, from which about one and a half pints of fluid, with some coagulated serum, escaped. The discharge was continuous and profuse; caused considerable rritation of the skin, as if from digestion; and patient is now perfectly well, a year after the operation.

This case is a well-marked example of false pancreatic cyst described by Mr. Jordan Lloyd in 1892, resulting from injuries to the pancreas,



By permission of the Bristol Medico-Chirurgical Journal.]

Fig. 1.—Gall-stones in gall-bladder, common duct, etc.

Fig. 2.—Stone in common duct, weighing 11 oz.

Fig. 3.—Pancreatic cyst in a boy, 7 years of age.

the patient continued to waste. The cavity was, therefore, washed out with weak adrenalin solution, and the patient was fed with raw and cooked sweetbread. After ten days the discharge rapidly diminished, the wound soon healed, and the from the pancreas in the retro-peritoneal region,

and it bears out the contention that the lesser peritoneal cavity tends to be involved. Such cysts have occurred between the ages of thirteen months and seventy-six years, and as they arise they are covered by three layers of peritoneum. In the case here recorded there is distinct evidence that the cyst first occupied the lesser peritoneal sac, and then involved the right loin through the foramen of Winslow. After the first operation the foramen of Winslow must have become closed, leaving a retention cyst in the lesser sac of peritoneum, which required subsequent drainage. This view is confirmed by the fact that Albert saw a bulging of such a cyst through the foramen of Winslow. The mortality of the recorded cases has been about 10 per cent.; and it will be interesting to observe whether my patient develops diabetes in the future.

## ORAL BACTERIA AND ACQUIRED IMMUNITY TO DISEASE.

By J. SIM WALLACE, M.D., D.Sc.

Those bacteriologists who have devoted attention to the mouth have been impressed by the fact that it seems to be remarkably well adapted for the development of micro-organisms. Thus the late Prof. W. D. Miller says:—"If we compare the life conditions of bacteria... with the conditions prevailing in the mouth, it becomes evident that the oral cavity must be an excellent breeding-place for these organisms. It is equally clear that both their number and variety are continually being augmented by new germs which enter with the air, food and drink."(a)

The fact that the mouth presents such excellent opportunities for the proliferation even of pathogenic micro-organisms has naturally been looked upon with a certain amount of alarm, for its position at the commencement of the alimentary canal seemed to signal it out as the very cavity of the body which should be kept most scrupulously aseptic. Yet it has been conclusively proved: (1) That even a healthy mouth is never free from micro-organisms; (2) that there are no secretions of the mouth which have any appreciable antiseptic or bactericidal effect; (3) that the cleansing of the buccal cavity results from the detergent action of food, drink and saliva; and (4) that the natural cleansing of the buccal cavity (or the removal of the bacteria and their products) is practically invariably accomplished by swallowing, or removing the bacteria and their products into the stomach. This all seems very dreadful and dangerous, but, on the other hand, we know, as a matter of fact, that, notwithstanding these conditions, disease does not normally supervene. The tissues of the mouth are particularly well able to resist the invasion of micro-organisms, and the stomach has the power to digest and kill the great majority of the bacteria which enter it, so that even although minute numbers of bacteria do gain entrance, disease does not supervene, because the tissues and the blood have a certain power of resisting the invasion of pathogenic micro-organisms. Disease only supervenes when the invading parasites overcome the natural defensive arrangements of the

"The first line of defence of the body resides, in all probability, in the epithelial tissues which oppose the entrance of infective agents into the body." "It clearly must be a local power residing in the epithelial cells themselves, or on the fixed cells on which they are situated, rather than any general condition, such as the presence of opsonins in the blood."(a) It is a somewhat significant fact that the tissues of the mouth are the most resistant to the invasion of micro-organisms. Even a severe injury—e.g., the extraction of a tooth, which, indeed, is little less than a compound fracture, is very rarely followed by the invasion of pathogenic micro-organisms beyond the seat of injury. The walls of the stomach may not be so resistant to micro-organisms, but the stomach has the special power of digesting the bacteria, so that invasion through the stomach or alimentary canal seldom takes place, and even though some few bacteria should escape being digested, they would but rarely, in a state of health, at least, induce disease, because the tissues are not nearly so likely to be affected by small doses as by large ones.

Now, without going into further detail, I think the above facts indicate that the entrance of disease via the mouth is very well combated in a state of Yet, when disease does supervene, it undoubtedly does so in many cases by way of the mouth and alimentary canal. This may in some cases result from a specially large or virulent dose of pathogenic micro-organisms, but more generally it may be supposed to result from diminished resisting power of the body resulting from injury, cold, starvation or irritants, which diminish the local resisting powers. A question naturally arises, however. Do the bacteria and their products which are normally swallowed produce any further immunity to the diseases which might, and occasionally do, supervene when the natural resistive powers are temporarily lowered from any cause? We know that the injection of vaccines under certain conditions renders the blood more immune to corresponding diseases. We know also that a similar immunity can be gained by swallowing the vaccines.(b) We are therefore led to believe that the bacteria and their products which are produced in the mouth may tend to establish a similar im-munity under normal and healthy conditions, provided the dose be not unduly large.

If this be so, it would help to explain why ubiquitous pathogenic micro-organisms are, as a rule, innocuous, except in specially large doses or under exceptional conditions. It would also seem to explain why epidemic diseases claim so many victims, for if they are but rarely present there is little or no acquired immunity to the diseases. When we remember, too, how certain races are so severely attacked when a new disease is introduced into their land, we are probably justified in suspecting that those races had not acquired the immunisation which other races had to these diseases. It seems possible that a gradual immunisation even to epidemic diseases may at times result from the harbouring of some of the disease germs in the mouth, and consequently from swallowing a certain number of them together with their toxins. Now, although there is no doubt an inherent difference in the susceptibilities of different individuals to certain diseases, it is probable that the more marked differences result more especially from acquired immunisation. It would be difficult otherwise to explain why a disease such as measles should have been so very deadly when first introduced to the natives of the Polynesian Islands, and within a generation have ceased to be nearly so deadly in its effects. It is not sufficient to say that the susceptible were weeded out and that a relatively insusceptible race has evolved. A type is remarkably persistent, and the extinction

<sup>(</sup>a) Sir Watson Cheyne. "The defensive arrangements of the body as illustrated by the incidence of disease in children and adults." Wightman Lecture, 1908.
(b) A. Latham. "Trans. Roy. Soc. Med.," 1908.

<sup>(</sup>a) "Micro-organisms of the Human Month," p.68.

of even large numbers in one generation will hardly produce any pronounced difference in any characteristic. It is much more probable that some individuals became immunised by having had the disease, others (the supposed insusceptibles) became immunised by way of the mouth, and their offspring became more or less immunised by way of the placenta. If vaccines can immunise by being injected or swallowed, there is no reason to doubt that the fœtus may be immunised through the placenta. I think we are justified in saying that, in addition to inherent immunity, we also derive immunity from the environment in which we live; in early life through the placenta, later through mother's milk, and lastly through the swallowing of their toxins.

Possibly toxins may be like some poisons: in small doses they may be beneficial, and the system may as it were become hardened to them.

It is not to be presumed that these facts or arguments would in any way justify us in introducing living pathogenic micro-organisms into the mouth even in minute quantities. For, although living micro-organisms seem to be absolutely necessary(a) in the alimentary canal, the introduction of pathogenic micro-organisms would be a very dangerous procedure in our present state of knowledge. Yet a hypothesis such as I indicate might help us to explain the immunity which some people seem to enjoy even when the mouth is in a most septic state. Mr. K. Goadby seems to believe in such an hypothesis; thus he says it is "possible that the property of natural immunity to many diseases is the expression of a gradually-developed tolerance to the attacks of micro-organisms evolved over long periods of time, and produced in a manner analogous to artificial immunisation.(b)

If we do not believe in a theory of acquired immunity such as I have tried to indicate, we would require to believe in each individual having a definite and hereditarily fixed amount of immunity, except in those cases where vaccination or disease had increased the natural amount. It would surely, however, be somewhat anomalous to conclude that the reaction to vaccines is not analogous to some natural process. Furthermore, it should be remembered that man is an animal having the power to adapt himself to almost any environment. It would again be anomalous to assume that in the matter of disease he was not capable of adaptation without the actual extermination of multitudes of his kind. At least, it seems to me more reasonable to conclude that he can gradually acquire immunity to ubiquitous diseases, and I would suggest that it is by means of the bacterial flora of the mouth, as indicated, that this comes about.

If the truth of the foregoing be granted, we see the extreme importance of a healthy, functional and physiologically clean mouth. It will readily be granted that a healthy mouth may be competent to deal with dangerous micro-organisms, but we shall not be so ready to admit this beneficent role when the mouth is dirty and fermenting after ill-chosen and ill-arranged meals, poisoned from carious cavities and suppurating gums, and functionless even in regard to the simple act of mastication and the insalivation of food in the mouth.

A NATIVE of Selukwe, Rhodesia, has been seized with sloeping sickness. It is believed that the disease was contracted at Quilimane, in Portuguese East Africa. It is declared that there is no danger of the disease spreading through infection.

(a) Halliburton's "Physiology," p. 510.
(b) "Mycology of the Mouth," p. 80.

#### OBSERVATIONS ON

#### THE PROVIDENT DISPENSARY.

BY GEORGE CRICHTON, M.A., M.D.

THE Provident Dispensary may be described in general terms as an Institution where people who are ill obtain medicine, they contributing to the cost by fixed weekly or monthly payments. In most instances these dispensaries have been started, and are maintained in part, by charitable contribu-That is to say, they are not completely nt. There is a group of provident distions. provident. pensaries called the Metropolitan Provident Medical Association, whose twenty branches have a membership of about 12,000 cards, including families, as well as single persons. They contributed about £5,200 last year, and the charitable public about £1,000, or nearly one-sixth of the whole. The management expenses amount to 11 per cent., for rent, caretakers, printing, etc. Only one branch in 1907 did not receive any addition from charitable funds, the average per card being 7s. 7d. The average of another branch is 5s. 7d. Members' payments vary from 1s. a quarter to 4d. and 6d. a month. The rules say there is a wage limit, but do not specify it. If 1 per cent, be a reasonable proportion of income for medical extendence that proportion of income for medical attendance, then ios, per annum would appear to be the proper contribution for a man earning £1 a week. It is quite evident that the average contribution, as above stated, is much too small, having regard to the means of the working classes. No statistics are given, and apparently the well-to-do workman is classed with the occasional out-of-work, and the donations given in the slump, not to particular cases. Where, for instance, the member's payment is 4d., enough should be contributed from voluntary charity to raise the whole to 6d. in that branch.

The total income being £6,200, the doctors receive £3,300, just above half, the management expenses and cost of medicines having first claim. Yet I suppose it is perhaps just as well to make up the medicine for every patient from a doctor's prescription. There is not a single item of information as to the payment received by the doctor per card or per case or per visit. From reports of other Dispensaries I gather that the payment the doctor gets is 3d. or  $8\frac{1}{2}$ d. per visit, or somewhere between these figures.

Can anyone tell me what is the minimum fee for a medical man to receive, so as neither to gain nor to lose? as if a shopkeeper were selling goods so as neither to gain nor lose—i.e., at cost price. I do not think it can be less than a shilling; including (or excluding?) medicine? More if the practitioner have the higher qualifications.

It is very difficult to get a clear and comprehensive view of the whole subject, but these two points seem clear: First, the contribution is too small from most (not all) of the provident members; second, the contribution and subscription combined should as nearly as possible afford a shilling per attendance to the medical officer. After thirty years the Metropolitan Provident Association, and those other Provident Dispensaries which appear mostly to work on the same lines, have a poor result to show. As to reform or improvements, of course, I understand that any increase must be small at first, also that gratis out-patient treatment at hospitals should absolutely cease.

Truly there is much to be done.

#### **OUT-PATIENT'S ROOM.**

METROPOLITAN HOSPITAL.

Retention of Urine.

By Dr. EARDLEY HOLLAND.

AMONGST those seen during the afternoon, the two following cases of retention of urine were of interest:—

The first was a single woman, æt. 36, who had been unable to pass urine since the early morning. The same thing had occurred once before, three weeks ago, and her doctor had had to use a catheter to relieve her. Except on these two occasions there had never been any trouble with the act of micturition. Questioned as to her menstrual history, she said she was perfectly regular, but that for the past six months the

periods had been profuse.

On examining the abdomen, a central, oval, fixed swelling was felt, reaching up to the umbilicus: it felt cystic and gave a fluid thrill on percussion. This was the bladder. Dr. Holland remarked that in all abdominal swellings arising from the pelvis in women, two possibilities should first be excluded, viz., pregnancy and distended bladder; if this simple rule were observed many mistakes would be avoided. The distended bladder was not always easy to diagnose from a fixed ovarian cyst by abdominal palpation alone. But Dr. Holland thought that the distended bladder has a peculiar feeling, which was easier to appreciate than to describe; it felt more superficial and closer under the skin of the abdominal wall than the ovarian cyst; this was especially the case when the fluid thrill was obtained. In an ovarian cyst a fluid thrill was only obtained with ease when the cyst was large, and distended the abdominal wall as a whole; in the case of the bladder, a thrill was obtained with ease in a swelling of moderate size which only distended a small area of the abdominal wall. If gentle pressure were made over a distended bladder, it always caused in the patient the painful sensation of a desire to micturate.

The golden rule in all such cases was obviously the passage of a catheter. This was done in the present case, and resulted in the passage of about four pints of urine. This was followed by the disappearance of the abdominal swelling, but deep down in the pelvis a hard, fixed, rounded tumour could be palpated. On bimanual examination, the cervix was found pushed forwards against the symphysis pubis by a hard, rounded, fixed swelling, which occupied the pelvis, and which was anatomically continuous with the cervix. Pregnancy being excluded, Dr. Holland said the case was certainly a large fibro-myoma of the uterus impacted in the pelvis, and causing retention of urine by pressure on the neck of the bladder. The patient was placed in the knee-elbow position, and with a finger in the rectum, forward pressure was made on the posterior surface of the tumour, which was easily pushed up out of the pelvis; a ringpessary was then inserted to temporarily keep the uterus from again falling backwards. The patient was advised to have the uterus removed as early as possible.

The second case was a married woman, æt. 32, who had had three children. The last period was three months ago, and she considered herself pregnant. For the past week she had had trouble in passing urine, the difficulty being chiefly in the commencement of the act; but since the previous night she had been absolutely unable to pass urine, and was now in

great pain.

Dr. Holland said that retention of urine; with a history of three months' amenorrhœa, was always a striking combination of two symptoms, and almost invariably meant incarceration of the retroflexed gravid uterus. The distended bladder reached the umbilicus, and was immediately relieved by the passage of a catheter. Bimanual examination showed the cervix pushed forwards against the symphysis by a softish, fixed swelling, which had well-defined borders, and

was anatomically continuous with the cervix. This was the enlarged pregnant uterus. Dr. Holland said that the next thing to do was to replace the uterus into its proper position and to keep it there. This was usually easy after the bladder had been emptied, and was often spontaneous. Pressure through the posterior fornix was unsuccessful in the present case, even in the knee-elbow position. Manipulation should not be violent or prolonged in these cases, for there was a risk of detaching a part of the ovum and causing abortion. The patient still being in the knee-elbow position, the cervix was seized with a volsellum, and the uterus drawn downwards away from the sacrum; at the same time the uterus was pressed forwards by a finger in the rectum. By this manœuvre the uterus was at once replaced. Dr. Holland said he had never known it fail, unless the uterus were bound down by strong adhesions; the whole point in it was drawing the uterus down away from the promontory of the sacrum, which often prevented it from passing forwards.

A ring pessary was then placed in the vagina to prevent a recurrence of the backward displacement of the uterus. This would be taken out in a month, by which time the uterus would have risen above the

promontory of the sacrum.

#### **OPERATING THEATRES.**

ST. THOMAS'S HOSPITAL

Obstruction from Carcinoma of Rectum.—Mr. Corner operated on a female, æt. 63, who had been ill for some weeks with symptoms of chronic or subacute obstruction. She had been worse for the past few days. On admission to the hospital she was found to be a very fat woman with distended belly; there was vomiting. Enemata were given without effect. The temperature was 99°, and the pulse 100. The abdomen was opened through mid-line below the umbilicus. There was a minimal amount of clear fluid, and the intestines were greatly distended and reddened; they were smooth and shiny, with no trace of fibrin about. An enormous sigmoid was brought out, ending in a small ring carcinoma at the upper end of the rectum. On attempting to bring the growth up, there was a squelch, and Mr. Corner said he thought he had torn the gut. Therefore, no more was done; a drain was stuffed into the pelvis. and colotomy performed. The patient made a good recovery.

RUPTURED SPLEEN.—The same surgeon operated on a boy, æt. 9, who had on the same morning fallen downstairs, injuring the left side. The patient had vomited once only. There was shock only on admission. Two hours afterwards the pulse had gone down from 98 to 86, but the boy looked bad, with very sunken face, and there was an area of flatness in the splenic region. Immediate operation was therefore decided upon. An incision was made through the left rectus. Dark blood showed up immediately on opening the transversalis fascia. The peritoneum was opened, and a quantity of blood escaped which, Mr. Corner pointed out, was fit usual character—that is to say, more recent red blood at the periphery and older dark blood in the flank. The spleen was found torn, and was removed. The progress of the case was good. The boy showed a certain amount of peritonism for 24 to 48 hours, but ultimately made a good recovery.

INTESTINAL OBSTRUCTION.—CARCINOMA OF SIGMOID.—The same surgeon operated on a female, æt. 49, who had been admitted with a history of chronic obstruction, with passage of mucus and blood, for two years on and off. She had suffered from subacute obstruction for a week. On admission to the hospital she was seen to be a fat woman, with distended belly. Nothing could be felt per rectum. At the operation the belly was opened through the left rectus. A small amount of clear fluid was found in the pelvis. A ring carcinoma of the signoid was discovered. Colotomy was performed. On the third day there were no untoward symptoms, and eventually the patient made a good recovery.

PADDINGTON GREEN CHILDREN'S HOSPITAL. Two Cases of Empyema.—Mr. Arthur Edmunds operated on two cases of empyema. The first was that of a boy, æt. about 6, with a history of six weeks' illness. After the periosteum had been lifted from a part of the seventh rib, which had been exposed by an incision a little posterior to the axillary line, a portion of the rib, about an inch long, was removed and sinus forceps inserted, when there was at once a gush of pus; a large amount having been evacuated, the cavity was thoroughly irrigated and a drainage

tube inserted. The second case was that of a boy, æt. about 6, who had a history of sudden dyspnæa which had occurred some four months previously. The peculiarity of the case was that there was some suspicion of a foreign body, perhaps a piece of match, having caused the symptoms and led to the formation of the abscess. The steps of the operation were similar to those employed in the previous case. The abscess those employed in the previous case. The abscess cavity was found to be small; Mr. Edmunds carefully examined it with his finger, but could detect no

case, and a drainage tube left in.

Mr. Edmunds said he always employed irrigation for the abscess cavity in these cases, although some surgeons thought there was a certain amount of danger in the procedure. He considered, however, that all risk was avoided if the irrigation was made with very low pressure; this was obtained by the vessel from which the solution flowed through the tube, being held very little above the level of the wound; by this means the liquid runs into the abscess cavity at a proceding in this way all very slight pressure. By proceeding in this way all cardiac danger was obviated.

#### TRANSACTIONS OF SOCIETIES.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

CLINICAL MEETING HELD APRIL 2ND, 1909.

Dr. SEYMOUR TAYLOR in the Chair.

THE following cases were shown and described by: Mr. PARDOE: A case of complete paralysis of the arm after excision of the elbow, following an accident. Scar dissected out, and the musculo-spiral nerve found to have been divided just above its bifurcation.

Anastomosis performed by end-to-end suture.

Dr. Frederick Palmer: Two cases of tabes dorsalis with unusual symptoms, and a case of habit spasm, in which irregular movements of the face, neck, head, and trunk muscles were markedly present.

Mr. N. BISHOP HARMAN: (1) A case of senile cataract with infantilism in a man, æt. 50, with the physique of a fat boy and penis of a boy of two years of age; well-formed scrotum, but no testes. (2) A case of chronic gouty conjunctivitis.

Mr. E. Archibald Smith: A girl, set. 18, with a

painless tumour of the tongue of ten years' duration,

probably a lymphangioma.

Mr. McAdam Eccles: A case of Charcot's ankle in a man, æt. 29, presenting symptoms of tabes dorsalis.

Skiagram showing much destruction of bony surfaces of tibia and astragalus.

Mr. CECIL H. LEAF: A case of excision of rectum for malignant disease by the abdomino-perineal method.

Dr. SEYMOUR TAYLOR: (1) A case of purpura. A heart from a patient who developed a loud bruit after sudden exertion, thought to be due to a torn aortic cusp, but found post-mortem to be due to an inflammatory deposit on the wall of the aorta just above the valve.

Dr. HALLS DALLY (for Dr. Abraham): (1) A case of dermatitis herpetiformis in a woman, æt. 39. (2) A case of bullous erythema in a boy, æt. 10. (3) A case of serpiginous syphilide in a woman, æt. 62. (4) A case of tricophyton endothrix on the scalp of a man, æt. 20, a contradiction to the statement of Dr. Sabouraud, of Paris, that the disease does not affect

adults.
Dr. E. C. Sparrow (for Dr. Saunders): (1) A case of myelo-cythæmia. (2) A case of Bazin's disease.

#### LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD APRIL 22ND, 1909

The President, Mr. T. H. BICKERTON, F.R.C.S., in the Chair.

#### Dr. A. A. BRADBURNE read a note on AMBLYOPIA EX ANOPSIA.

He dealt with that type found in conjunction with high degrees of refractive error. He considered the cause to be a cerebral defect, and based his treatment on that theory. He quoted one of his cases, a boy, at. 11, who had in six months' special training recovered vision from 5/50 to 5/5, or Jaeger I. He considered that want of success in treatment was due to the defect being a complex one, the visual act

depending on several centres.

Mr. NIMMO WALKER advocated the whole-time covering of the non-squinting eye until the vision of the squinting eye became equal to that of the other. This was possible in the majority of cases if taken early

Mr. R. C. Dun read a note on intussusception based on an analysis of 73 cases. He argued in favour of irrigation, followed, if necessary, by immediate section. Ether was always the anæsthetic used.

Dr. Hubert Armstrong discussed the paper.

Dr. Wilson read a paper on the SERUM DIAGNOSIS OF SYPHILIS.

Wassermann and Noguchi's tests were described, and their value contrasted. Using Wassermann, 23 results were positive out of 30 cases. Of 20 controls, 3 were positive, but in none of these could the possibility of syphilis be excluded. With Noguchi, 40 out of 52 cases syphilis be excluded. With Noguchi, 40 out of 52 cases were positive; also 3 out of 25 controls. Out of 30 cases submitted to both tests, 22 were positive with both, 4 negative with both; 2 were positive with Wassermann, and negative with Noguchi; 2 were negative with Wassermann, and positive with Noguchi. The opinion expressed was that Wassermann, although the more complicated of the two, was the more reliable.

Dr. Ernest Glynn referred to the fact that some cases of cancer growth gave the Wassermann reaction, and that a guinea-pig's heart was as suitable an antigen as syphilitic liver. The serum principle had been successfully employed in the diagnosis of typhoid and gonorrhœa.

#### CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, APRIL 22ND, 1909.

THE preliminary business was to elect a Chairman for the ensuing year. Dr. Champneys was unanimously voted to the chair, with a hearty vote of thanks for his past services.

Sir George Fordham was re-elected Hon. Treasurer,

and among the correspondence was a letter announcing his re-appointment to represent the County Councils Association on the Board for the period of three years ensuing April 1st. A letter from the Secretary of the Royal College of Surgeons of England reported that Mr. Cuthbert Hilton Golding-Bird, F.R.C.S., had been appointed to represent the College on the Board in place of Mr. J. Ward Cousins, F.R.C.S., retired.

In reply to a communication from the Secretaries of the Jubilee District Nursing Congress to be held in Liverpool, May 12th-14th, the Board decided to send two delegates, considering it advisable that in any important discussion on maternity work there should be some one present with recognised authority to speak on these matters. Miss Rosalind Paget and the Hon. Mrs. Chas. Egerton were nominated as delegates.

MEDICAL PRACTITIONERS "COVERING" MIDWIVES. In reply to a further communication from Dr. A. G. R.

Foulerton, County Medical Officer for Fast Sussex, as to medical practitioners "covering" midwives, it as to medical practitioners. Governing interviews, in was agreed that, subject to Dr. Foulerton's consent, the Board should forward the letters to the Privy Council, with the object of obtaining an opinion as to whether a certified midwife personally delivering a woman in childbirth is acting as a midwife where a medical practitioner has been engaged to attend the medical practitioner has been engaged to attend the case. In accordance with a wish expressed by the Chairman, Sir Wm. Sinclair had obtained from the heads of lying-in institutions in Prussia, Saxony, Russia, Norway, and Denmark particulars of the regulations applying to midwives in those countries which he now laid before the Board. It was agreed that a letter of thanks to each of these gentlemen be cant by the Secretary, enclosing a copy of the rules sent by the Secretary, enclosing a copy of the rules framed by the Board, and the recently issued report of its work since its constitution.

Letters were read from the Medical Secretary of the British Medical Association as to the supervision the British Medical Association as to the supervision of midwives approved for the purpose of undertaking the practical training of pupils. To the first of these the Secretary had replied stating the requirements of the Board before granting "Approval to sign Forms III. and IV., such approval only lasting one year; at the expiration of that time a further recommendation was required from the local supervising authority." Sir Wm. Sinclair thought more supervision was necessary. There was no evidence before the Board of evasion of rules by approved midwives. the Board of evasion of rules by approved midwives. It was agreed finally to reply that the Secretary's first letter embraced all the information required, but the Board would at any time be glad to be put in possession of any specific evasion of the rules which came to the knowledge of members of the British Medical Association.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

#### FRANCE,

Paris, April 25th, 1989.

TINEA CAPITITIS.

RADIOTHERAPY is, without doubt, the best treatment of tinea tonsurans. But the practitioner who lives far from a large town is obliged to prescribe a less modern treatment.

As a preliminary treatment the hair should be cut as close as possible and each patch of tinea treated by epilation.

Three times a week the whole scalp should be rubbed

Tincture of iodine, 1 oz.

Proof spirit, 4 oz.

And the other nights with the following unguent:— Pyrogallic acid, 15 gr.

Cade oil, 1 dr.

Vaseline, 5 dr. Each morning the head is washed with soap and hot water.

After a few days of this treatment, the parasite should be attacked.

The spots are washed with spirits of chloroform (5 per cent.), and finally with the above iodine solution. The diseased hairs are expelled by producing artificial folliculitis by means of pure croton oil applied with the end of a match enveloped with cotton or with a mitigated pencil:—

Croton oil, Cacao butter, } 1 dr.

The following day pure tincture of iodine is applied; after three days a wet dressing softens the crusts which can then be easily removed. The croton oil should be renewed every ten days. The treatment lasts at least nine or ten months.

Radiotherapy is, as has been said, the most effectual treatment of tinea tonsurans. The patch to be cured should be exposed, says M. Sabouraud, at a distance of six inches from the centre of the ampulla of Villard. During the first days of the treatment no apparent result is seen, but towards the seventh day a slight redness is observed. Depilation commences towards the fifteenth day and is soon complete.

The X-rays seem to affect the pilary papillæ, which progressively cease their function; the hair falls spontaneously charged with living parasites, for the X-rays do not kill the trichophyton. The treatment lasts three months.

General treatment is of but secondary importance. However, these patients being generally of lymphatic temperament, a series of tonics might be useful: codliver oil, syrup of iodide of iron, arsenic, sulphur baths, etc.

Tinea of the beard may be treated by epilation and application of tincture of iodine, or a modified form of that employed for tinea capititis.

Trychophyton of the nails is best treated by curettage and a permanent bath of iodine:

Iodide of potassium, 10 gr.

Iodine, 10 gr.
Water, 1 pint.
Each night a piece of absorbent cotton is steeped in this liquid and wound round the finger, which is then covered with an elastic fingerstall.

Or apply each night with a hair pencil:-

Acetone, 3 oz. Cade oil, 2 dr. Iodine, 15 gr. CHRONIC RHEUMATISM.

The local treatment of chronic rheumatism addressed both to the painful element and to the inflammatory phenomena of the articulations.

To relieve the acute or sub-acute pain so frequently observed, preparations with salicylate of methyl as a basis, are the most frequently employed:—

Chloroform, 5 dr. Salicylate of methyl, 5 dr.

Camphorated oil, 3 oz.

Or a liniment composed of equal parts of oil and

essence of winter green.

The German doctors recommend the application of compresses wet with a solution of phenic acid (2 or 3 per cent.).

Ointments composed of belladonna and cocaine are sometimes useful:

Hydrochl. of cocaine, 15 gr. Ext. of belladonna, 1 dr.

Vaseline, 5 dr.

Lanoline, 5 dr. in cases, M. Dieulafoy recommends a In certain cases, M. Dieulafoy recommends a poultice which Trousseau was wont to employ. This consists of bread-crumb moistened with water, placed

in a sand bath during three hours, after which it is thoroughly mixed with spirits of camphor until it has the consistence of putty; it is then spread on a cloth and coated with the following mixture:—

Camphor, 2 dr. Ext. of opium, 1 dr. Proof spirit, q.s.

The poultice is directly applied to the joint and covered with impermeable tissue, and left on for eight or ten days.

Against the inflammatory phenomena of the joints, tincture of iodine is utilised or the actual cautery, and sometimes a blister.

M. Teissier frequently uses dermatol, which has a vaso-constrictive action, useful against vascularisa-tion; it has also sedative properties:—
Subgallate of bismuth, 2 dr.

Vaseline, 1 oz.

Massage, says Dr. Dardel, of Aix-les-Bains, can render great service, not only as regards the general nutrition of the patient, but also for the nutrition of the muscles and the function of the articulation. However, it should be done with prudence, and only when all inflammation has ceased.

Electricity has been employed for a long time in the different forms of chronic rheumatism; faradic currents are especially useful to prevent muscular atrophy; while under the influence of continued currents the pain in the joint subsides and the periarticular contractions are favourably modified.

To apply the currents, the positive pole, under the form of a large electrode, is applied to the cervicodorsal or dorso-lumbar region, according to the seat of the rheumatism; the extremities of the patient are placed in a porcelain basin filled with warm salt water put in communication with the negative pole. Each day a stance of from 8 to 25 minutes with a current of from 8 to 25 milliamperes is practised. The negative pole may also be applied directly over the joint.

Baths have been used from time immemorial, but are specially indicated in the chronic form following acute rheumatism. They may be either simple or medicated (sulphur or arsenical baths). Vapour baths are sometimes very useful, while hot-air baths, according to the Tallerman-Sheffield system, are capable of

rendering great service.

It is impossible to say, concludes Dr. Dardel, to which of these methods preference should be given as the results obtained vary with the form of the rheumatism and the condition of the patients, consequently one has frequently to proceed gradually, trying one and another, until the treatment proper to that one case is discovered amongst the diverse methods.

In extreme cases, surgery may step in, but more particularly in rheumatism of the knees. Here resection has been followed by cessation of pain, and, although the patient recovers with an ankylosed joint, yet the function of the limb is much improved. In polyarthritis deformans, an operation (section of the tendons or aponeurosis) permitting straightening of the limb, can render service.

#### GERMANY. Berlin, April 25th, 1909.

At the Verein für Innere Medizin, Hr. Fleischmann gave the results of some experiences in the

INTRAVENOUS ADMINISTRATION OF STROPHANTHIN.

The experiments were carried out by a medical student, Hr. Wjasmansky. He said that the favourable reports made by some authors on the intravenous injection of strophanthin necessarily led others to make observations themselves. The preparation made use of was not Böhringer's, which was used by most authors, but the g-crystallised strophanthin Thoms (g-strophanthum crystallisatum Thoms). The advantage of the preparation was that it was a crystalline product, whilst all other strophanthin preparations were amorphous powders, which might vary more or less in their composition, especially as the mother drug—the strophanthin seeds—was a mixture of various seeds, whilst strophanthin was prepared from a well-characterised species, strophanthus gratus.

The results of the treatment were to some exteut brilliant, especially in cases of disturbance of compensation. In the shortest time—in a few minutes—a complete reversal might be brought about in the objective symptoms—frequency of pulse, dyspnœa—as well as in the subjective condition. If complete compensation in cardiac cases only occurred in the milder ones after a single injection, much less digitalis was required than usual—not more than a fourth or half. The cardiac complications of renal cases were also suitable for the treatment. Only moderate results appeared in the cardiac weakness of infectious diseases, also in the tachycardia and heart weakness of cachectics. A total of 52 injections of Thom's strophanthin were made on 30 patients. The dose was from 0.0003 to 0.0005 g., dissolved in 1 ccm. of water, and furnished in sterilised ampullæ. No case of sudden death, as observed by some authors, came under notice. It was to be noted that strophanthin was distinguished from digitoxin in that the latter only acted as a constrictor of the splanchnic vessels, whilst strophanthin acted on the whole of them.

Hr. Stadelmann had made experiments with uabain. By subcutaneous injection it was not so painful as digalen. The dose by intravenous injection was 3 decimilligrammes. The drug often acted like magic, but not in all cases. He believed that two or three cases of sudden death were to be laid at the door of uabain.

It appeared to be especially dangerous in arteriosclerosis of the coronary arteries. It hal to be used with great care.

Hr. Fleischmann did not know whether uabain was identical with strophanthin.

A discussion on the

TREATMENT OF INFECTIVE DISEASES OF WOUNDS

took place at the Basel Chemical Society, introduced by a paper by Prof. C. Haegler. He said that the idea of destroying germs by antiseptics was to be given up, once for all. Disinfection of inflamed tissues was impossible.

If he did not reject a moderate use of impossible. If he did not reject a moderate use of antiseptics, he could only recognise their usefulness in the direct destruction of bacteria. The bactericide serums had also proved deceptive. It was only from allied organisms that a useful serum could be obtained for our wound infection-carriers. The attempt to obtain serums for staphylococci and streptococci had failed even in the laboratory. Nothing could be done directly with the bacteria and their toxines. We must therefore try to raise the resisting power of the organism. Passive hyperæmia was not suitable for general practice, but he could recommend active hyperæmia (Preissnitz dressings, thermostats, etc.). If the affection could not be cut short, it could at least be limited. If the pain and febrile symptoms did not improve, surgical measures should not be delayed. Tension of the tissues demanded the scalpel, if extenwere to be avoided. All cavities should be plugged or drained; no "mêchen" resting position or suspension of the inflamed extremity. The kind of dressing and the technique were of importance. He was in favour of moist dressings. Prof. von Herff heartily agreed with what the speaker had said. He gave a special greeting to his warning not to injure the wall of granulation tissue. This was specially applicable to the treatment of puerperal fever, a true wound infection. Here a simple avanination might do harm fection. Here a simple examination might do harm, and still more scraping, which the speaker looked upon as a mistake. An infected wound could not be made germ-free at once, but gradually by the use of antiseptics to destroy the germs. But the behaviour of the various germs in the presence of the various antiseptics must be more attended to than it had been. Staphylococci bore carbolic acid the worst; pyocyaneus, acetate of alumina; diphtheria, phagedænic ulcers, above all hospital gangrene, salicylic acid in 2 per cent. of glycerine, or, still better, a 10 per cent. alcoholic solution; anærobic gas formers, peroxyde of hydrogen, and generally speaking oxydants and halogenes. Gonococci were also very susceptible to halo-genes—iodine—as was noticeable in the treatment of gonorrhoea in the female; silver might be made use of, but it was less effective than iodine. It was known of, but it was less enective than logune. It was known that this fungus was particularly susceptible to pernanganate of potash, applicable in treating children. Excitors of decomposition were readily attacked by aniodol, therapogen, and salol. The latter was excellent in a 1 per cent solution prepared from a 10 per cent alcoholic solution in offensive discharges of care lent in a 1 per cent. solution prepared from a 10 per cent. alcoholic solution in offensive discharges of carcinoma uteri. Aniodol had also proved very service-able in diphtheritic cystitis. Mercury was at once destructive for the monilia species, the fungus improperly called oddium, which frequently set up troublesome inflammations of the vulva.

He agreed with the unfavourable judgment of the reader of the paper regarding serum treatment. Col-

He agreed with the unfavourable judgment of the reader of the paper regarding serum treatment. Collargol was useless as regarded bacteria; possibly it bound up poisons by absorption, as the general condition of patients often improved after its use.

He had given up Bier's hyperæmia in mastitis, but he was friendly to dry tamponade with xeroform, and opposed to powder dressings, which only did harm. Commencing furuncles could be aborted by mopping with drops of 20 per cent. iodine, or liquefied carbolic acid, if applied at their first appearance. Furunculosis was best met by alcoholic washings, with spirit dressings, and the timely application of 2 per cent. tr. iodi. Instead of Peru balsam he employed tr. benzoin with great advantage.

Hr. Barth recommended tr. iodi in cases of infected

wounds and furunculosis.

## AUSTRIA. Vionna, April 25th, 1909.

DIABETES MELLITUS. Ar the Gesellschaft für Innere Medizin, Noorden gave the members a complete history of a case of diabetes which he had cured with a vegetable diet. The patient was a young man, set. 22, whose body weight had fallen to 45 kilogrammes, or 6 st. 4 lb. The urine contained large quantities of sugar, acetone, The urine contained large quantities of sugar, acetone, and acetic acid when admitted. The patient was first strictly limited to the usual diabetic diet, with 25 to 75 grammes of bread in the 24 hours—i.e., \(\frac{3}{4}\) of an ounce to 2.65 oz., which represented the total amount of carbohydrates. During this time he was passing 70 to 140 grammes of sugar in the 24 hours. The enormous amount of ammonia, 2.8 to 3.8 grammes per day, pointed to a large amount of salt in the urine. The analysis revealed about 20 grammes of ovphutyric soid analysis revealed about 20 grammes of oxybutyric acid and 2 to 3.8 grammes of acetone present. After two days' vegetable diet the sugar sank to 58 grammes, or nearly 2 oz., but the ammoniacal salts still stood at 3:3 grammes. After this the patient was given an oatmeal diet to increase the absorption of carbohydrates, as he was now in a serious condition from acid intoxication. The first day 250 grammes, or about half a pound, of the oatmeal preparation was administered, with wonderful restorative effects; the second day the quantity provided was less, but the analytical results were more unfavourable, as the sugar in the urine rose to 136 gremmes, or 4.6 oz., but the ammoniacal bodies were only 0.9 of a gramme, and the oxybutyric traces, the the orbit a gramme, and the oxputylic traces, the latter only being encouraging. Meat diet was given the next two days, the sugar still rising in the urine, but the acetone fell to 0.4 of a gramme. He was again put on vegetable diet till the amount of sugar per day fell to I gramme, with hardly a trace of acetone. With the exception of the two days on oatmeal, his diet was confined mostly to one free of carbohydrates up to this period. Again, 250 grammes of oatmeal per day were administered; the acetone could scarcely be detected; the vegetable diet was repeated and again followed by the oatmeal, the actione rising to 0.1 of a gramme. The same variety was followed for a few days till only a trace of sugar and acetone was found in the urine, the patient enjoying excellent health and

increasing in body weight. The sugar present in the blood when first admitted was 0.16, 0.15, and by the end of February was 0.18

was 0.15, and by the end of February was 0.18 per cent., the normal being 0.07 to 0.08.

Here we had hyperglycæmia with an abnormal retention or power of resistance in the kidney. After a short period the patient was again tried with carbohydrates, and 50 grammes of coarse bread given, but the sugar rose to 50 grammes a day in the urine. The patient from first to last, or from February to December 100 metabot to 100 metabot 100 metabo ber, 1908, was kept on a rigid diabetic diet, with the exception of these experimental tests, while he performed his daily employment, and increased in weight by 10 grammes. At the end of nine months a regular diet of 75 grammes of bread, half a litre of cream, and an apple were given in the 24 hours. More recently 300 grammes of potatoes have been added to that diet, and no trace of sugar or abnormal bodies are found in the urine. The patient is, therefore, using 60 grammes of carbohydrates without any trace of sugar in the urine.

#### REFLEX ANURIA.

Latzko, at the Gesellschaft der Ærzte, showed a that time there was severe pyelitis, with a large abscess, which was diagnosed at the time from a large amount of pus taken from the left ureter, while the right secreted normal urine. In July, 1908, the right secreted normal unine. In July, 1900, the patient again became ill with severe colic in the right side, or supposed healthy kidney, which was associated with persistent vomiting, anuria and headache. These attacks repeated themselves every 14 days, but the anuria continued in spite of catheterisation. Blocking of the ureter or hydronephrosis was suspected. Fourteen days previously he operated and found in the lower pole of the right kidney, embedded in the parenchyma, two calculi. The patient is now perfectly well since the operation.

#### FROM OUR SPECIAL CORRESPONDENTS AT HOME,

**BELFAST** 

ULSTER HOSPITAL FOR CHILDREN AND WOMEN.-The annual meeting of this hospital was held last week, Mr. G. W. Wolff, M.P., presiding. The medical staff report gave an account of increasing work in The medical every department, and increasing need for further accommodation. The hospital is worked on most economical lines, the average cost per patient per day being only as. 4d., while if patients, nursing staff, and servants are included, the average cost is only is. 63d. per head per day. Plans have been prepared for a new hospital, for which there is ample space, thanks to the wise forethought of those who moved the hospital to its present site about twenty years ago, and building will be proceeded with as soon as the necessary sum of £10,000 has been collected. Wolff has promised £1,000 on condition that no building is done till the whole sum is in hand, and other subscriptions have been given on the same understanding, amounting in all to over £5,000, so it is hoped that the whole amount will soon be subscribed. Dr. R. W. Leslie and Dr. J. D. Williamson, among other speakers, described the work of the hospital, and appealed for help.

SCARLATINA EPIDEMIC AT LURGAN.-A smart epidemic of scarlatina has broken out at Lurgan, co. Armagh, and is taxing the local accommodation to the utmost. At the last report there were about fifty children in the Lurgan Workhouse Hospital, and the small-pox hospital had to be utilised to accommodate some of them. The fever is of a pretty severe type, and there have been several fatal cases.

SALARY OF THE MEDICAL OFFICER OF HEALTH.-SALARY OF THE MEDICAL OFFICER OF HEALTH.—
Rather a flutter has been caused in municipal circles by a snub administered by the Local Government Board to the Public Health Committee of the Corporation. It will be remembered that on Dr. Whitaker's resignation of the post of Medical Officer of Health in 1906, a great effort was made to induce or force the Corporation to offer a sufficient salary to draw forth well-qualified candidates for the post, and in these efforts the Local Government the post, and in these efforts the Local Government Board joined. But in spite of all efforts, the Corporation did what had been predicted in these columns many months before; they appointed a general practitioner who had only lately resigned his seat on the Corporation, and who had no special qualifications for the protections for the control of the tions for the post. Now, when public indignation has died down, and attention is taken up with later scandals, the Public Health Committee proposes to raise its officer's salary by 500 per annum to \$800, but the Local Government Board has refused to sanction this, calling to mind its protests when the appointment was made. "The Board cannot lose sanction this, calling to mind its protests when the appointment was made. "The Board cannot lose sight," they say, "of the fact that the Corporation, after full deliberation, less than three years ago, assigned £600 as the remuneration for the work, and that Dr. Bailie accepted office on these terms, and, having regard to their usual practice of declining to consider proposals to increase salaries until five years have elapsed after the appointment, on the ground that the fixing of a low initial salary would tend to limit competition and discourage eligible candidates. they feel unable to concur in the present proposal of

the Corporation."

QUEEN'S UNIVERSITY: APPOINTMENT OF PROFESSORS AND LECTURERS.—A number of new appointments are about to be made in Queen's College in connection with the foundation of the new University. None of them are directly medical, but several of them are in the science school, and will more or less affect students of the preliminary medical subjects. They include a professorship of botany (till now united with zoology), and lectureships in physics, organic chemistry, bio-chemistry, and geology. The University Commissioners have been at work during the Easter recess, and it is still hoped that the new scheme of work will come into force next autumn, though some pessimistic persons predict that things cannot possibly be ready.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

#### DOCTORS AND MIDWIVES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—Will you allow me, in reply to Dr. S. J. Ross's letter in your issue of April 7th, to say I believe, from what I have heard, that there are places in the British Isles—"remote places," some would call them—where the skilled aid of a well-trained nurse would be welcomed by the medical man, who could not call upon a medical man or woman for assistance simply because there would be none in the district to whom he

could apply. I cannot give the names of those places,

but I daresay any medical agent could.

"I cannot," says the late President of the British
Gynæcological Society (Mr. W. D. Spanton, F.R.C.S.),
in his inaugural address, "leave this subject without
expressing my conviction that some of our best results are secured for us by those skilled nurses who know our ways, whose loyalty to the surgeon is unquestioned, and whose sole desire is to save the patient's life by devoted, unswerving attention and watchful-Such are as rare as they are invaluable, and I am sure you will agree with me in frank acknowledgment that much of our success as gynæcologists

is due to their assistance." Permit me to point out to your readers that I have been chiefly applying my remarks to ladies who are employed by missionary societies in those countries where women only are allowed to medically attend women and children, where there is no medical man or woman, and to those ladies who give their services as unpaid volunteers. The reports of all missionary societies utter the same cry—"We want medical men and women to fill posts where there is no medical man or woman." And this cry of need applies, not only to the component countries of the British Empire, but also to South America and other countries not under British sway. Let me quote some extracts from the quarterly magazine of the Zenana Medical Mission College and Hospital:—"Sir Patrick Manson, K.C.M.G., in his address at Livingston College, said:- 'Those who send out missionaries to work in foreign lands should lay to heart the importance of medical knowledge to a missionary. It is not fair to anyone to ask a man to go abroad to face unavoidable risks. Martyrdom is one thing, suicide is another, and murder—though he did not like to say the word—is a third; yet to send a man or woman abroad to work as a missionary in unhealthy climates, and not provide them with proper information as to how to prevent themselves being killed—he left his hearers to say what that would be. If the supporters of missionary institutions demanded that the missionaries sent out should have some instruction in caring for health, they would only be doing their duty.'

Here is what one traveller writes who has witnessed the needs we cannot adequately portray, and her words but express the wants of many places in other lands:—
"Just think—from Karachi to Bagdad, among the populous cities of the Persian Gulf, of the Tigris and Euphrates, throughout Arabia, throughout South and South-West Persia-not a medical man! From Bagdad to Teheran—almost the most populous district of Persia—not a missionary nor medical man! The great oasis of Ferghana, at a height of 7,000 ft., with 680 villages craving medical advice, never visited, scarcely mapped."

Here is another testimony: - "There was no medical man within 1,200 miles, and we were sometimes compelled to act, whether we knew or not, and we found a small smattering of information . . . was or the utmost advantage to us. I hope that all missionaries who go where there is no doctor at all will get as much knowledge as they possibly can."

"The profession" is said to be overcrowded. Why, when I started in practice about half-a-century ago, the same cry was all around me; I was told, "Oh! a small smattering of information . . . was of the

the same cry was all around me; I was told, "Oh! you'll starve; you'll have to give in; every place is occupied by medical men" (there were in those days no medical women).

It is not more crowded now than then, if we bear in mind the increase in the world's population, and the number of countries that have been opened up within the time to which I refer-viz., the early 'sixties. I write this to encourage those who are now young not to be daunted by any such cries, nor to be turned aside by any seemingly insurmountable barturned aside by any seemingly insurmountable parriers, but to temember the Latin poet's trenchant words, "Possunt quia posse videntur," which Paul and our missionaries would translate, "I can do all things through Christ, Who strengtheneth me."

I am, Sir, yours truly,

G. DE G. GRIFFITH.

London, S.W.

DENTISTS AND ANÆSTHESIA

To the Editor of THE MEDICAL PRESS AND CIRCULAY. SIR,—As a dentist with full qualifications on The Medical Register, I should like to add my voice to those who are pleading for justice to qualified dentists helding only the L.D.S. in the matter of the administration of anæsthetics; and I trust you will give us your powerful support. To prevent these men from giving "gas" or applying local anæsthetics will be to inflict undeserved hardship, not only upon them but also upon the public of the public and the public also will be them, but also upon the public. A clause could be easily inserted in the Bill specifically naming nitrous oxide as the agent that dentists might use; and giving them authority to employ obtundents of pain by injection into the gums. Some few years ago the injection into the gums. Some few years ago the General Medical Council being appealed to, declared that qualified dentists might legitimately administer "gas." It must be borne in mind that gas is not a deadly agent; and in the vast majority of cases can be given with perfect safety by the average qualified dental practitioner. Its safety lies in the fact that unlike chloroform, and similar agents, it does not in itself produce toxic effects, and accumulate in the blood. Gas, unless in very rare cases, can kill only by the deprivation of oxygen, and thus a deadly result can be brought about only by extremely prolonged inhalation. As soon as air is admitted the effects pass off; there is no poisonous dose to be got The number of deaths recorded from gas, including those occurring in the hands of totally unqualified men, does not amount to one in hundreds of thousands of cases. It would be unfair to dentists to deprive them of the privilege which they now enjoy; and unfair and unjust to the less wealthy classes of the public who cannot afford to pay the fee of a fully qualified anæsthetist for a simple operation like tooth extraction.

I am, Sir, yours truly, L.R.C.P., M.R.C.S., L.D.S.

London, W. April 24th, 1909.

#### SPECIAL ARTICLES.

#### .THE FORTHCOMING XVIIL INTERNATIONAL CONGRESS OF MEDICINE, BUDAPEST.

THE detailed arrangements for the Sixteenth International Congress of Medicine are now issued with a list of the Committees and a programme of the communications promised to the Sections. The meetings of the Congress will be held in the buildings of the former Polytechnic School Museum-korut 6/8, but the formal opening will take place in the banqueting hall of the Municipal Redoute at 11 a.m. on Sunday, August 29th, 1909. The closing ceremony will occur at the same place on September 4th, 1909, at 10 a.m. Six general sittings will be held during the Congress, at which addresses will be delivered by Prof. Baccelli, at which addresses will be delivered by Prof. Baccelli, of Rome; Dr. Bashford, of London; Prof. Kutner, of Berlin; Dr. Laveran, of Paris, and Mr. J. Loeb, of Berkeley, U.S.A. A journal will be issued daily, and there will be the usual secretarial offices and bureaus. Three new sub-sections have been formed, viz.: Orthopædics; Professional Hygiene; School Hygiene.

The arrangements for lodgings are dealt with below,

but the General Secretary calls attention to the difficulty of finding adequate accommodation for intending visitors to Budapest unless they give timely notice to "The Central Travelling Ticket Office iv Vigadó-ter I. Budapest, Hungary," and secure room by paying for them in advance. Certain concessions will be allowed by the railway companies to members attending the Congress. In Hungary the railways allow a reduction of 50 per cent. In France the management of the State railways and the East, North, and Orleans Companies also allow a 50 per cent. reduction to members provided with the proper vouchers; whilst in England the Great Eastern Railway grants a reduction to Congress members. Members of Congress who have paid their subscriptions will receive a circular about the end of May informing them of the method of claiming these reductions.

#### EXCURSIONS.

The Executive Committee offer six excursions for members after the Congress, each excursion being personally conducted and upon the ordinary inclusive terms, the first-class prices admitting of a single bedroom in hotels, whilst those who pay second-class will be lodged in couples. The first excursion costs 150 crowns first-class, and 135 crowns second-class (a crown is equivalent practically to a shilling). It includes a visit to Kolozsvar, the ancient capital of Transylvania, the Marosujvar salt mines, and the Rév. Pass. It leaves Budapest on September 4th and returns on September 7th

Excursion No. 2 is to the High Tatra, Dobsina Ice Cavern, and Postyen Baths, leaving Budapest on September 4th and returning September 9th. Price, 180 crowns first-class, 150 crowns second-class.

180 crowns first-class, 150 crowns second-class.

Excursion No. 3 is to Lake Balaton, which is one of the largest and most beautiful in Europe. Members leave Budapest on September 4th and return on the 6th. Price, 130 crowns first-class, 110 crowns second-class.

Excursion No. 4, the Lower Danube and Herkulesfürdő, leaving September 4th and returning September 8th. Fare, 185 crowns first-class, and 155 crowns second-class.

Excursion No. 5, Constantinople, leaving Budapest September 4th and returning September 13th. Price, 475 crowns first-class and 375 crowns second-class. This excursion requires passports visted at the Turkish and Roumanian Consulates. It allows five days in Constantinople. The excursionists, having visited Constantinople, may return vid Trieste by putting into Athens and Corfu, the additional price being 425 crowns. Constantinople is left on September 11th, and Trieste is reached on September 16th.

Excursion No. 6, Bosnia, Herzegovina, Dalmatia, and the Hungarian Littoral, leaving Budapest on September 4th, and returning on September 12th. First-class, 320 crowns: second-class, 270 crowns.

The latest date of entry for any of the excursions is

The latest date of entry for any of the excursions is August 1st, and in each case a booking fee has to be paid, varying from 25 to 50 crowns, which is not repayable under any circumstances. Some of the excursions are necessarily limited in number, so that early application is desirable. So far as can be told at present, the Congress appears to be viewed with favour by the medical men of the United Kingdom, for it has secured a larger number of adherents than any of the Congresses since the one held in Paris. Communications should be addressed to the Hon. Secretaries for Great Britain, Dr. Clive Riviere and D'Arcy Power, Esq., F.R.C.S., 10A Chandos Street, Cavendish Square, London.

#### HOTELS AND LODGINGS.

The arrangements made for lodging members who attend the forthcoming Congress at Budapest are given in a circular letter dated April 15th, 1909. The letter is sent by the Central Travelling Ticket Office, iv Vigadó-ter, I. Budapest, Hungary:—

"We have been entrusted to find accommodation for the partakers of the above-mentioned Congress, and this we perform in advance and for the whole duration of the Congress by issuing 'accommodation orders.' The period of validity for such accommodation orders is seven days with hotels and eight days with private dwelling-houses, and it is to be understood that the day of arrival with hotels is August 28th, but with private dwelling-houses August 27th. Should the arrival at Budapest take place after August 27th, or with hotels after August 28th, and the departure from Budapest before September 4th, no reimbursement will be made for the time the lodgings are unused. At the same time we are able to dispose of chambers at the following prices:—

"In Hotels—Arrival on August 28th and departure on September 4th.—Rent for a stay of seven days (prices in kronen): Series A.—Single-bedded, 70-140k.; double-bedded, 84-210k.; three-bedded, 105-245k. Series B.—Single-bedded, 48-69k.; double-bedded, 64-83k.; three-bedded, 80-104k. Series C.—Single-bedded, 21-47k.; double-bedded, 35-63k.; three-bedded, 42-70k.

"In private dwelling-houses—Arrival on August 27th, departure on September 4th.—Rent for a stay of eight days (prices in kronen): Series D.—Single-bedded, 51-70k.; double-bedded, 75-100k.; three-bedded, 91-115k. Series E.—Single-bedded, 31-50k.; double-bedded, 45-75k.; three-bedded, 61-90k. Series F.—Single-bedded, 45-60k. (For practical purposes kronen may be reckoned as the equivalent of shillings).

"Such chambers must be engaged in the following.

"Such chambers must be engaged in the following way:—The person who orders lodgings indicates in which series and at what price he desires a single-bedded room, or one with two or three beds, and whether in an hotel or in a private house. It is left to the choice of him who engages the room to fix the price between the maximum and the minimum rent, and the amount corresponding with the price chosen must be sent to us in advance. In return for it, and in conformity with the order received, we remit the sender an accommodation order for an appropriate lodging.

lodging.

"To recompense our trouble and expenses in securing accommodation, the Presidency of the Congress has stipulated a commission of 8.50k. per person. This commission is to be sent at the same time as the rent, and the receipt of it will be acknowledged separately, because the accommodation order only acknowledges the receipt of the rent which we have to pay for the respective lodgings without any deduction.

"In case the renter should be prevented from coming and taking possession of the lodgings—notice of which, however, must reach us before August 20th—the rent paid in advance will be refunded upon production of the accommodation order, with a deduction of 10k. a head; should such notice reach us after August 20th 20k. will be deducted per person.

a head; should such holice reach as after regard 2 20k. will be deducted per person.

"You will oblige us very much by taking into-account the tables above mentioned, fixing upon a room suitable to your purpose, and by kindly remitting to us the corresponding rent, in addition to the commission, whereupon we shall immediately deliver you the necessary 'accommodation order.'"

The text of this communication is given without comment, though members who propose to avail themselves of the proposals contained in it are requested to consider it carefully, and to keep every document in connection with their bargain, as failure to produce written evidence of the contract proved a fruitful source of trouble at the Madrid meeting of the International Medical Congress.

#### OBITUARY.

THE LATE SIMEON SNELL, D.Sc., F.R.C.S.ED.
THE following appreciatory notice has been sent by a personal friend:—

a personal friend:—
Simeon Snell, that bluff and hearty West-Countryman, died at his residence, Moor Lodge, Rutland Park, Sheffield, on April 17th last, after an illness that had lasted for several months. He possessed a most attractive personality, together with a potentiality for work that was simply amazing. He was never idle, and, indeed, did not seem to know the meaning of the word. As he once remarked to the present writer, he wished "the day contained not twenty-four, but forty-eight

hours." His large private practice, his duties in connection with the University of Sheffield, and his immense clinic at the Sheffield Royal Infirmary would have given ample occupation to most men. Not so Snell. He made time during his busy life to act as sophical Society, of which he afterwards occupied the Presidential Chair. His was the hand that guided the amalgamation between that Society and the old Sheffield Book Club. In conjunction with the late Mr. J. D. Leader, Snell wrote the "History of Sheffield Royal Infirmary," an institution to which he was attached in the capacity of Ophthalmic Surgeon for many years. He founded and edited the Quarterly Medical Review. Snell filled a large and honourable part in the public life of his adopted town, Sheffield. For many years he had been a Justice of the Peace, and a touching tribute was paid to his memory only the other day by the solicitors practising in the local police court. Nobody did better work than Snell in the movement that led to the foundation of Sheffield University. He addressed many meetings in Sheffield University. He addressed many meetings in Sheffield and district, and in that way rendered yeoman service to the scheme. Snell filled many posts with much acceptation. He was, as already said, Ophthalmic Surgeon to the Sheffield Royal Infirmary, and was besides Professor of Ophthalmology at the University, Ophthalmic Surgeon to the Blind School, and, most important of all, filled at the time of his death the distributed of the Sheffield of the Sheffield at the said t Important of an inheat the thine of the British Medical Association. He had been Vice-President of the Ophthalmological Society of the United Kingdom. As a practical surgeon, Snell took front rank. He was an accomplished operator, and at the Royal Infirmary (where there is a special eye block) he used to exhibit with some pride a large wide-mouthed bottle filled to repletion with cataractous lenses that he had removed from Infirmary patients. On a rough estimate, the receptacle must have contained several hundred lenses. Snell's was essentially a practical mind. This was shown by the nature of his work, which, in the main, may be said to have dealt with the diseases and accidents of industrial life. He was the greatest authority living on that curious affection, miners' nystagmus, and his work on the extraction of foreign bodies from the eyeball by the electro-magnet is known the world over.

APRIL 28, 1909.

It was evident to his friends that he was far from well when the British Medical Associatian met last summer in Sheffield. Still, he managed to compass the more important work. He seldom appeared in the Section of Ophthalmology, although at the end of the session he gave a most interesting luncheon at the Infirmary to many of its members. Snell's old teacher, Mr. Pridgin Teale, F.R.S., had come from retirement to make one of the party, and so had Dr. Argyll Robertson, who now, alas! has joined the majority. Professor Fuchs, of Vienna, and Professor Axenfeld, and Freiburg were also present. Not the least touching of Freiburg, were also present. Not the least touching feature was the presence of Mr. Michael A. Teale, son of the veteran Teale, and of Mr. Snell, son of the host. A good man has gone. May his soul rest in peace! SYDNEY STEPHENSON.

#### SEPTIMUS GIBBON, M.D.CANTAB., F.R.C.P.

WE regret to announce the death of Dr. Septimus Gibbon, at his London residence, at the age of 84 years. Deceased was the son of Mr. William Gibbon, surgeon, of Kettering, Northamptonshire. His grandfather, whose name was MacGibbon, came from Edinburgh

Dr. Gibbon won an exhibition to Clare College, Cambridge. He was resident House Physician at Addenbrooke's Hospital, and took his degree of M.B. in 1851, and the M.R.C.P. of London in 1852. He afterwards proceeded to St. Bartholomew's, where he was a pupil of Sir James Paget. During the war in the Crimea he went out with Miss Florence Nightingale to the British Civil Hospital at Smyrna, of which he

After a year's service he returned home and set up in practice in London, being an Assistant Physician at the London Hospital. He was Sanitary Officer of the

National Hospital for Paralysis and Epilepsy, and Medical Officer of Health for Holborn for nearly 40 years, and was one of the oldest managers of the Natural Philosophy at St. Bartholomew's Hospital, and was well-known in the City. He was editor and proprietor of the Pulpit and Ecclesiastical Review till within a few months of his death. Dr. Gibbon married, in 1858. Janet, eldest daughter of Thomas Jacomb, and leaves two sons and three daughters.

#### ROBERT HARRISON WILSON, M.D.DURH.,

M.R.C.S.
WE regret to announce that Dr. Robert Harrison Wilson, one of the oldest medical practitioners in the North, died suddenly last week at Tynemouth. He had not been well of late, but was out for his customary walk in the morning at Tynemouth, where he has resided for two years. He was taken ill, and died in the afternoon. Born at Howdon ill, and died in the afternoon. Born at Howdon eighty-two years ago, Dr. Wilson commenced practice in Gateshead early in the 'fifties, and came into great prominence for his efforts during the cholera epidemic which raged in 1854. Previous to taking up his residence in Gateshead, Dr. Wilson held an appointment at Newcastle Infirmary. For some years he was Poorlaw medical officer in Gateshead, and up to his death was an hon. physician of the Dispensary. Six years ago he retired into private life his practice being conago he retired into private life, his practice being continued by Dr. Norris and Dr. Moore Ede, and two years ago he removed to Tynemouth. Dr. Wilson was a magistrate.

#### REVIEWS OF BOOKS.

#### INFANT FEEDING. (a)

THERE is, perhaps, no subject on which medical students, and practitioners for that matter, are so badly informed as infant feeding. It is one which is usually utterly neglected in the medical curriculum, and yet in actual practice it is of first importance. In fact, infant feeding is a national question, and demands the immediate attention of every medical man. As a rule, books on the subject are too theoretical to be of any help to the seeker after knowledge. He has to grope about amidst a labyrinth of theory. Facts are what he wants, but they are hard to find. This cannot be said of the book under review. The first impression one gets after reading its pages carefully and critically is that it is pre-eminently practical. Dr. Fowler, on the very first page, refers to gain in weight as a valuable sign of successful artificial feeding, but he is careful to point out at the same time that some infants, even though putting on weight, may be developing rickets. In such cases the feeding cannot be looked upon as a success. Too often reliance is placed on this gain in weight as an absolute sign that the child is doing well. This to our mind, and evidently to the author's, is one of the commonest of fallacies.

Dr. Fowler insists on the impossibility of finding a food identical with woman's milk. Human milk, as he points out, possesses specific natural properties which cannot be imitated artificially. Regarding the digestion of milk proteids, the author evidently favours the views recently put forward by Van Slyke and Hart. A somewhat original scheme of casein digestion is given by way of illustration which puts the matter in a light which will prove new to many. Dr. Fowler rightly condemns the use of preservatives as a means of sterilising milk. Boron preservatives are bad enough, but hydrogen peroxide is, in our opinion, much more likely to do harm. Buddised milk has, author's experience, frequently caused scorbutus in infants fed exclusively on it. He maintains, however, that the use of sterilised milk is probably not a cause of scorbutus. Among the poor he advocates boiling the milk for 5 to 10 minutes as being safe and satisfactory. Buttermilk has, in the author's hands, proved very

(a) "Infant Feeding. A Practical Guide to the Artificial Feeding of Infants." By J. S. Fowler, M.D., F.R.C.P.Ed., Physician to the Royal Hospital for Sick Children, Edinburgh. London: Henry Frowde. 1909.

successful in certain selected cases of chronic gastrointestinal disorder. His experience, however, in producing Luttermilk artificially by means of cultures of lactic acid bacteria has not been encouraged. Regarding proprietary infant foods, Dr. Fowler writes:-"Most proprietary foods are inadequate, usually in fat; all are liable to produce scurvy. Claims that they are identical with human milk are wholly illusory." This sentence is but one of many truths contained in this admirable volume. The medical man who follows the teaching contained within its pages will not go very far astray. Although the subject has been treated from a scientific standpoint, the book is essentially practical in its style. It is written by one who knows the many pitfalls that beset the uninitiated when dealing with the difficulties of infant feeding.

THE URIC ACID FACTOR IN DISEASE. (a) DR. HAIG'S opinions are now so well known to the profession that any detailed criticism of the seventh edition of his work is unnecessary. Originally published in 1892, the book has grown considerably, and the present edition contains nearly a thousand pages. The course of his investigations has not led Dr. Haig to modify in any material point the views that he put forward sixteen years ago, but has rather tended to strengthen his belief in the truth of those views. Stated shortly, these views are that many functional and organic diseases are the result of the accumulation of uric acid in the blood and tissues, and that this uric acid is mainly derived from animal food. The treatment is obvious: avoid taking uric acid in food, and the cause being thus removed, the effect will disappear. One must not, however, be disappointed if the result does not completely come up to one's expectations, for our bodies, like those of our forefathers, have been damaged to a serious degree by prolonged poisoning. One has the comfort, however, of knowing that those who follow us some three or four generations hence will reap the benefit of our abstinence. Like other special pleaders, our author is so taken up with the demonstration of his own special views that he has no time for the consideration of other matters. If we take, for example, the chapter which deals with headache, we find that the "uric acid headache" is, in Dr. Haig's opinion, the same as migraine, but in the causation and treatment of this condition we do not find anything said about eyestrain as a cause, or its removal as a form of treat-ment. Surely, in the treatment of this disease, the neglect to investigate the condition of the eyes would the be a grave omission on the part of any physician. The book reminds us not a little of a play that had some vogue a few years ago, and which, though it contained much truth, could hardly be looked on as a complete exposition of pathology and therapeutics.

OUR TEETH. (b) THE importance of sound teeth to the well-being of the race is gradually coming to be recognised by the medical profession, not only as an asset in itself, but also as a means of preventing many diseases the result of bacterial infection. The public have not yet got satisfactory ideas on the subject, but signs are not wanting that such ideas are beginning to be recognised. Perhaps the most striking evidence of the nised. Perhaps the most striking evidence of the wrong ideas which too many people hold about teeth is to be found in the view so commonly expressed about the temporary teeth of children. If the attention of parents is directed to decayed teeth in the mouths of their children, how often do we hear the answer, "It is only their first teeth, and so does not matter." The result of this is too often seen in our dental hospitals in the numbers of young men and women who apply to have extensive extraction operations performed in order to get fitted with artificial dentures. If the teeth of the adult are to be good, too much attention can hardly be paid to the temporary teeth of the child.

A remedy can only be found for this by the education of those in charge of children in the necessity of attention to the child's teeth. The book before us is an endeavour to help on this education, and as such we extend it a hearty welcome. We think it a pity, however, that our authors have devoted so little space to what we look on as the most important part of the book-how to preserve the teeth. Instruction for the public in such matters must be dogmatic, and we fear that the admirable chapters dealing with the growth and formation of the teeth will tend to limit rather than to increase the utility of the book where it is most needed. We trust, however, that it will find many readers not only among the public, but in the profession, for, if it does, good can hardly fail to result to succeeding generations.

#### LITERARY NOTES.

THE present volume of the great American work, "Index-Catalogue of the Library of the Surgeon-General's Office," includes references under the words, periodicity and others up to "Prussia," and includes 5,966 author titles, representing 3,250 volumes and 4,851 pamphlets. It also contains 7,678 subject-titles of separate books and pamphlets, and 40,221 titles of articles in periodicals. The list takes in such important subjects as peritonitis, perityphlitis, phagocytosis, plague, pleurisy, pneumonia, and pregnancy. It would be almost impossible to exaggerate the importance and value of this Index-Catalogue to the THE present volume of the great American work, portance and value of this Index-Catalogue to the student of medicine, and medical men throughout the world are under a deep debt of gratitude to the U.S. Government for their liberality in providing such a work.

MR. RUDVARD KIPLING'S many admirers will be glad to have in permanent form the address on "Doctors," delivered to the students of the Middlesex Hospital last October. (a) The address loses none of its eloquence or freshness in re-reading. It is here accompanied by a Preface from the hand of Mr. Reginald Lucas, which deals with the history of the Middlesex Hospital. The Preface is interesting, but eleven pages of Mr. Lucas to introduce eight pages of Mr. Kipling seems to show a lack of sense of proportion. Less necessary still is the reprinting of Oliver Wendell Holmes' mediocre verses on "The Two Armies." The booklet is sold for the benefit of the Middlesex Hospital.

H. K. Lewis has in preparation a new book on "Immunity and its Applications in the Diagnosis and Treatment of Infectious Diseases," by Dr. D'Este Emery, the author of "Clinical Bacteriology and Hæmatology," which has reached its third edition. The book aims at giving a clear outline of the main facts and theories in regard to immunity, and is not written in support of the view of any particular school. It is intended in the main for students commencing the study of the subject or for practitioners wishing to learn the scientific basis and exact mode wishing to learn the scientific basis and exact mode of application of the modern methods of diagnosis and treatment of the infectious diseases. The book also contains a Glossary of Terms and an extensive Bibliography. The Lectures delivered at the University of London in February, 1909, by Dr. Louis C. Parkes, under the trust of the late Sir Edwin Chadwick, and also just ready for publication. The Parkes, under the trust of the late Sir Edwin Chauwick, are also just ready for publication. The official title of the course was "The Medical Aspects of Recent Advances in Hygiene as Connected with Sewering," but Dr. Parkes has called the book, "House-Drainage, Sewerage, and Sewage Disposal in Relation to Health." The same firm has just issued a fourth edition of Binnie's "Operative Surgery." The service of the Extremities has been omitted but in section on the Extremities has been omitted, but in spite of this the revisions and extensions increase the number of pages and illustrations, over the third edition.

<sup>(</sup>s) "Uric Acid as a Factor in the Causation of Disease," By Alexander Haig, M.A., M.D. Seventh Edition. 8vo, pp. xii. and 940. London: J. and A. Churchill. 1908.

(b) "Our Teeth: How Built, how Destroyed, how Preserved."

LORGON: J. and A. Churchill. 1908.
(b) "Our Teeth: How Built, how Destroyed, how Preserved."
Described and illustrated by R. Denison Pedley, F.R.C.S.Ed.,
L.D.S.Eng., and Frank Harrison, M.R.C.S.Eng., L.D.S.Ed., 8vo, pp. 97.
London: Blackje and Son, Ltd.

<sup>(</sup>a) "Doctors." By Budyard Kipling. With a Preface. Pp. 31. ondon: Macmillan and Co. 1908. Price is net.

#### THE MEDICAL PRESS. 435

#### MEDICAL LITERATURE, RECENT SUMMARY OF ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

Werthelm's Pan-hysterectomy for Carcinoma of the Werthelm's Pan-hysterectomy for Carcinoma of the Cervix.—Berkeley (Journ. Obst. and Gyn. of the British Empire, XV., 3).—For the purposes of this paper the author sent a private circular to every recognised gynæcologist in the United Kingdom. The number of cases thus collected of radical abdominal operations for cancer was 313, of which 243 were Wertheim's. The fact that if a Wertheim's operation is to be performed, whatever else is done, the varing must be formed, whatever else is done, the vagina must be clamped across below the growth before it is divided, seemed to the author not to be generally recognised. The author discusses the following points: What advantage has Wertheim's operation over simple advantage has wertherm's operation over simple vaginal hysterectomy, and what over para-vaginal section. With regard to simple vaginal hysterectomy, he considers: (1) Primary mortality. This is undoubtedly high, but, with increased experience, can be lowered. This is shown by Wertheim's results. Of the 243 cases collected by the author the mortality was 18.1 per cent.; that of all the radical operations (313) is 18.5 per cent. This compares badly with vaginal hysterectomy, in which the mortality with different operators varies from 14 to 4 per cent.; but this fact should not deprive patients of the chance of cure, as, after all, this increased mortality is mostly because cases of a much more advanced and serious nature can be and are treated. If the percentage mortality is reckoned according to whether the case is one of early, moderate, or advanced type, the author finds in 238 cases collected the following results:—In 33 early cases, 6.3 per cent.; in 19 moderate cases, 5.2 per cent.; in 186 advanced cases, 23.1 per cent. (2) Percentage operability is greatly increased by the radical abdominal operation, because one is able to separate the bladder, rectum, and ureter from the growth without much risk of injury, whereas by the vaginal route out much risk of injury, whereas by the vaginal route this is impossible in a large number of cases. It was not possible to estimate the percentage operability from the reports collected, but on the Continent this varies from 46 to 90, and probably about 60 per cent. represents the true figure. This is greatly in advance of vaginal hysterectomy, the highest return of which is 31, and in the experience of English operators is nearer 12. (3) Percentage of cures. If the uterus is removed by vaginal hysterectomy, practically all the parametrium is left behind. By Wertheim's method all the parametrium is removed, and also a large portion of the cellular tissue. The results of the pathological investigation of the parametrium of a large number of cases has convinced the author that this should always be removed. The parametrium is infected in 60 per cent. of the cases, and therefore half the vaginal operations are useless. The pathological findings have proved that it is impossible to The pathodiagnose clinically the real condition of the parametrium. since a hard one may contain no cancer and a soft one be full of cancer. Five years appears to be the period chosen by most authorities, after which a patient may be said to be cured. tics collected by the author are useless for the purpose under discussion, as nearly all the operations have been done within the last two years. On the Con-tinent the standard is fulfilled. Wertheim has 62 per cent., and others vary down to Bumm, with 30 per cent.; but, in comparing these, it must be taken into account the varying percentage operability of the different operators. Wertheim has 49; Bumm, 90. In looking up the statistics of vaginal hysterectomy, the author found percentages of cures after five years to author round percentages of cures after five years to vary from 12 to 1.2. In comparison with this, Wertheim's operation shows a vast improvement, and this the author considers is due to two facts—one, the removal of the parametrium, the other the prevention of infection by clamping the vagina below the growth. In the past recurrence of cancer after removal of the

diseased cervix has nearly always been local from cell implantation, while after Wertheim's operation local recurrence is a rarity. Even if the percentage of cures with Wertheim's operation was no better than by vaginal hysterectomy, still the actual number of cases would be greater owing to the increase in operability. The author also points out that even when recurrence does take place, the patients do not suffer the same wertheim's operation with Schauta's para-vaginal section, the chief point for discussion seems to be whether there is any benefit to be derived from the removal of the regional glands. Theoretically there is any benefit to be derived from the removal of the regional glands. much in favour of the removal of the glands, and, if this were possible, it would be a strong point in favour of the abdominal route; but, in fact, it is impossible, and statistics seem to show that nearly always when glands have been removed and found to be infected there has been a recurrence. Besides this, the removal of glands prolongs the operation, and so increases the primary mortality. Viet, Pankow, and Wertheim hold that the routine extirpation of glands does not help the case, and the latter remarks that since in only one-third of the cases are the glands involved, the routine removal is detrimental to two-thirds of the cases, and increases the primary mortality in them. The occasional cure of a case in which the glands are infected does not counterbalance the extra mortality due to routine extirpation. If it is considered that the removal of the glands is not beneficial, the question of Wertheim's or Schauta's operation is a matter for personal choice by the operator, as the statistics of the two operations are almost similar as regards operability and permanent cure, while Wertheim's operation shows a higher primary mortality, probably owing to the removal of glands. The author deals with the complications which may arise during Wertheim's operation. On the question of drainage there seems to be some divergence of opinion. Many surgeons have given up draining the peritoneal cavity, while, on the other hand, Bumm claims to have reduced his mortality from 47 to 15 per cent. by stitching the peritoneum to the edges of the vagina and so leaving free drainage of the peritoneal cavity. The author also illustrates a single clamp, to take the place of the two clamps used by Wertheim for closing the vagina below the growth.

Primary Carcinoma of the Fallopian Tube, and the Report of a Case.—Norris (Surg., Gyn., and Obst., VIII., 3).—The author reviews the previous literature on this subject, and has collected 23 reported cases since 1904, which, together with those collected by Doran, and reported in 1905, brings the total number to about 86. He concludes that the condition is about 100 times as rare as uterine cancer. The growths can probably be all classified under the two heads papillary and alveolar, the former being by far the more Inflammation usually precedes the cancer. The condition may occur as a degeneration of a benign papilloma, but is usually primarily malignant, of rapid growth, and gives early metastasis. The symptoms are watery, blood-stained leucorrhea and atypical hæmorrhage, usually occurring between 40 and 50 years of age. The symptoms are often masked by those of pre-existing pelvic inflammatory disease, and the condition found on pelvic examination usually simulates this. A tube the seat of a cancer usually resembles a hydrosalpinx until the contents are examined. author's case was æt. 27, and had a history of pelvic inflammation four years previously. There was induration at both sides of the uterus, which was somewhat fixed by inflammatory masses at the sides and posterior, and the diagnosis made was bilateral pelvic inflammatory disease. The uterus and appendages

were removed owing to the advanced stage of the inflammation. The pathological examination of the specimens showed inflammatory disease of both appenspecimens showed inflammatory disease of both appendages, but the lumen of the right tube was occupied by a papillomatous growth of definitely malignant type, and at no part suggesting a benign tumour. The other organs were quite free from any suggestion of malignant growth. This seemed to be confined to the inner portion of the right tube. The age of the patient was considerably under the average was considerably under the average.

Persistent Bacteriuria.—Geraghty (Johns Hopkins Hospital Bulletin, January, 1909) discusses this subject, giving notes of cases under his own observation. He finds that the organisms most commonly present are the staphylococcus albus and the bacillus coli communis. The condition he believes to differ only in degree from ordinary cystitis. In one the infection is present without any inflammatory reaction on the part of the bladder wall; in the other the infective agent is in the urine, and there is also involvement of the vesical mucosa. He has never heard of a case in which the bacteriuria was due to any of the more strongly pathogenic organisms, such as the staphylococcus aureus. He therefore concludes that only slightly pathogenic organisms can produce bacteriuria, the more strongly pathogenic producing an inflam-matory reaction. It is found that the bacillus coli does not alter the reaction of the urine, whereas the staphylococcus albus turns it alkaline, and a troublesome phosphaturia may arise. The author in all his own cases attempted vaccine treatment with vaccines made from the patient's own organism, but the results were entirely negative.

#### MEDICAL NEWS IN BRIEF.

#### Royal College of Physicians of Ireland—Presidential Dinner.

THE President of the Royal College of Physicians of Ireland entertained his Excellency the Lord Lieutenant, the Fellows of the College, and a number of his other friends at dinner in the College Hall on Saturday last. After dinner, which was most admirably served, the toasts of the King, the Lord Lieutenant, and the President were duly proposed. His Excellency, in the course of his speech, referred at length to past medical history, and particularly to old Irish medical worthies. After the toasts the guests adjourned to the Statue Hall of the College, where a very pleasant musical programme was gone through. His Excellency gave particular pleasure to the company by singing

#### Medical Sickness and Accident Society.

At the usual monthly meeting of the Executive Committee of this Society, held on the 16th inst., it was reported that as usual at this time of the year the number of sickness claims are large; but for the most part they have been of short duration, and the total amount disbursed in respect of them is less than in the corresponding period of last year. mittee examined the drafts of the quinquennial valuation and annual report. The business of last year was exceptionally good, and the twelve months working has for its result a substantial increase, both in the number of members and in the financial reserves of the Society. The quinquennial valuation report will also be found to be good and the Committee will be enabled to recommend to the members a continuance of the payment of the liberal scale of bonus arranged for in 1904.

#### Incorporated Institute of Hygiene.

A MEETING of the members and associates of the Northern Counties Branch of the Incorporated Insti-tute of Hygiene was held at Rutherford College, New-

castle, on April 22nd, Mr. J. R. Hedley in the chair.
The Chairman, in addressing the members, said
whilst it was well known, and he might say an acknowledged fact, that England was equal to, or even in advance of many countries in what might be called

municipal hygiene, he was afraid they could not regard themselves as equally advanced in the knowledge of hygiene of domestic life. In this science he had every reason to believe both France and Germany excelled, but they excelled only because they had been less apathetic, because they had not been content, generation after generation, to take things as they were. It was to such bodies as the Institute of Hygiene that they must look for advancement in these

Dr. Appleby, the hon. secretary, referred to the work of the past year and remarked upon the success in the number of members. At the beginning of the winter session a class was formed at Rutherford College for the special training of those who wished to take up a course of study in school hygiene. As would naturally be expected those engaged in the teaching profession formed the greater part of that class, and he had no doubt the numbers who had attended were indications both of the importance school teachers attached to that particular branch of their work and the need there was for that knowledge.

Councillor Dr. Stewart drew attention to the necessity

there was for the spread of knowledge in the ordinary

details of nursing of everyday life.

Dr. T. M. Clayton, Medical Officer of Health, Gateshead, said he agreed with the remarks of Dr. Stewart. Not until the women of this country recognised their home responsibilities and equipped themselves to meet those requirements, would any improvement take place in their homes.

## Society for the Relief of Widows and Orphans of Medical Men.

A QUARTERLY Court of the Directors of the above Society was held on Wednesday, April 14th, Dr. Blandford, President, in the chair. Eleven directors were present. Since the last court, three members of the Court had died—Mr. T. Laurence Read, Vice-President, and Dr. Eastes and Dr. Chas. Baker, directors. A vote of condolence was passed to the directors. A vote of condolence was passed to the families of these gentlemen. Application for membership had been received from two medical men, and they were duly elected members of the Society. One of the annuitants, an orphan, had died. Her mother, up to the time of her death, had also been in receipt of grants. The father had paid in subscriptions £14 14s., and his widow and orphans had received from the funds of the Society £960. Five letters asking for relief had been received from widows of medical men, but this had to be refused, as their husbands were not members of the Society. Membership is open to any registered medical practitioner who at the time of his election is resident within a twenty-mile radius of The subscription is two guineas per Charing Cross. annum, and relief is only granted to the widows and orphans of deceased members. Full particulars may be obtained from the Secretary, at the offices of the Society, II Chandos Street, Cavendish Square, W. The invested funds of the Society now amount to over (100,000. Thursday, May 20th, was fixed for the annual general meeting, due notice of which will be posted to the members on May 1st.

#### PASS LISTS.

#### University of Aberdeen.

At the Spring Graduation at this University on April 6th, the following Degrees were conferred:—
Degree of Doctor of Medicine (M.D.).—William Angus, M.B., Ch.B.; Robert Chalmers, M.B., Ch.B.; Horatio W. A. Cowan, M.B., C.M.; James A. Davidson, M.B., Ch.B.; James Raffan, M.B., Ch.B.; Alexander H. Skinner, M.A., M.B., Ch.B.

The Degree of Master of Surgery (Ch.M.). was granted to James Robertson, M.D., Ch.B., with Honours, for his Thesis on "The Newer Methods in the Diagnosis of Urinary Disease."

Degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.).—\*Alexander Greig Anderson, M.A. (with Second Class Honours), \*William Anderson, David M. Baillie, John A. Beattie, James C. Bell, Douglas W. Bruce, Alexander At the Spring Graduation at this University on

J. D. Cameron, Arthur H. Duckett, William M. Duguid, Naughton Dunn, M.A., James Elder, John D. Fiddes, M.A., B.Sc., George C. Grant, Adam Gray, Herbert Hargreaves, John Inkster, \*William W. Jameson, M.A., Harold G. R. Jamieson, John Johnston, Clement R. Macleod, John McPherson, Angus Macros \*Charles A Macson M.A. John J. Mannier Johnston, Clement R. Macleod, John McPherson, Angus Macrae, \*Charles A. Masson, M.A., John L. Menzies, Robert J. Merson, Herbert S. Milne, John Mitchell, Dawson C. Robertson, Finlay G. M. Ross, Herbert A. Smith, George C. Soutter, Douglas M. Spring, Augustus G. Stewart, M.A., Robert Sturrock, Charles C. Twort, Alfred J. Williamson, M.A., Alexander Wilson. (\* Passed Final Professional Examination with this literature 2009) with "Distinction.")

Diploma in Public Health.—George Davidson, M.B., Ch.B.Aberd.; John Ferries, M.B., Ch.B.Aberd.; Alexander F. MacBean, M.A., M.B., Ch.B.Aberd.; Rae McRae, M.B., Ch.B.Aberd.; Arthur J. Milne, M.B., Ch.B.Aberd.; William G. Watt, M.B., Ch.B. Aberd.; Thomas C. M. Young, M.B., Ch.B.Aberd.

## Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

THE quarterly Examinations of the above Board, held in Edinburgh, were concluded on 19th inst., with

the following results:-

the following results:—

The following candidates passed the First Examination:—Samuel Wright, Claud Aldeus Slaughter, Jamshed H. Apoo, Hormazd A. Topalia, Joseph Muller, Walter Lessey, Bhajiwalla F. Limji, James G. Lessey, Hugh G. Anderson, Vasudeo D. Nimbkar, Sara A. Anthoni, Robert B. Galt, Evan Ithel Parry, and 6 passed in Physics: 3 in

Sara A. Anthoni, Kopert B. Cart, Evan Time, Larry, and William Bird; and 6 passed in Physics; 3 in Biology, and 10 in Chemistry.

The following candidates passed the Second Examination:—Robert H. Thomson, Stanley D. Large, Alexander E. MacKenzie, Frederick R. Lucas, John R. Smith, Arthur Butterfield, Octavus W. Bateman, William F. Gibb, Thomas R. G. Melrose, Frank D. Johnson, Kedar Nath, Victor T. W. Eagles, James A. Frost, John Ross, Emmanuel P. Ghose, Husain Buksh, Prabooth C. Banerjee, and William W. W. Watt; and 2 passed in Anatomy and 9 in Physiology.

The following candidates passed the Third Examination:—Joseph Muller, Charles G. Timms, Robert M. M. Wilson, Baboorao G. Shiroadkar, Charles L. Ievers, Richard Parry, Jugal K. Sharma; and 5 passed in Pathology and 6 in Materia Medica.

The following candidates having passed the Final Examination were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—James Robert Le Touzel, Canada; Charles Liston Stewart, India; Hargobind Lal Batra, India; Bhola Nath, India; Charles William Gee, Wigan; Thomas Mohan, Ireland; Harold Webb Gee, Wigan; Inomas Monan, Ireland; Harold Webb Garcelon, America; William Rutherford Waddell, Belfast; Claude Ernest Watts, Dewsbury; Frederick Robert Watson, New South Wales; Stanley Welton Hogg, New South Wales; John McKelvey, Belfast; Henry Hollister Jackson, Victoria; Alexander McMurray, Belfast; Albert Edward Herat, Ceylon; William William Control of the Cont Whitfield, Ireland; Robert George Sherlock, Jamaica; Whitfield, Ireland; Robert George Sherlock, Jamaica; James McTurk, Wales; Andrew Johnstone Brown, Edinburgh; Jehangir Munchershaw Mehta, Bombay; Jal Maneckji Mody, Bombay; Thomas Graham Shand, Greenock; Ralph Holwell Gray, Hants; Kharshed Nowroji Khory, India; Martin Luther Burke, Jamaica; Thomas James George, England; Jehangir Edulji Spencer, Hydrabad, Deccan; and 8 passed in Medicine and Therapeutics, 12 in Surgery and Surgical Anatomy, 22 in Midwifery, and 25 in Medical Jurisprudence. Medical Jurisprudence.

#### The Royal University of Ireland.

THE following candidates have passed the under-

mentioned examinations :-

The M.D. Degree Examination.—Daniel Gillespie, M.B., B.Ch., B.A.O.; William R. Hayden, M.B., B.Ch., B.A.O.; Robert Johnston, M.B., B.Ch., B.A.O.; William I. Leighton, M.B., B.Ch., B.A.O.; Andrew Leitch, M.B., B.Ch., B.A.O.; Robert McCarrison, M.B., B.Ch., B.A.O.; James H. Stewart, M.B., B.Ch., B.A.O.

The M.B., B.Ch., B.A.O. Degrees Examination.—

Upper Pass.—Edward Forbes, Patrick Keelan, Alan Kidd, James M. O'Connor, B.A., Thomas Taylor, Verner Wiley, John M. Williams.
Pass.—Thomas P. Carroll, John A. Clarke, B.A., Edgar M. Condy, William T. Henderson, William F. Hooper, Caroline V. Lowe, Samuel W. McComb, John P. Moore, Harris Newman, Peter H. O'Connell, James I. O'Kelly, B.A., Edward O'Reilly, Robert H. Robinson, William H. Sheffield, Michael Shipsey, William S. R. Steven, Standish I. Watson, Bruce A. West.

West.

The following candidates may present themselves for the further examination for Honours in the subjects mentioned after their names:—Thomas P. Carroll, Midwifery; Edward Forbes, Midwifery; Patrick Keelan, Midwifery; Alan Kidd, Medicine; Peter H. O'Connell, Surgery; James M. O'Connor, B.A., Medicine, Surgery, Midwifery; James I. O'Kelly, B.A., Medicine; Verner Wiley, Medicine, Surgery, Midwifery; John M. Williams, Medicine.

The following candidates have passed the Second Examination in Medicine:—

Udden Pass.—Samuel R. Armstrong, Thomas P.

Upper Pass.—Samuel R. Armstrong, Thomas P. avv. Norman B. Graham, B.A., Thomas Hill, Davy, Norman B. Graham, B.A., Thomas Hill, James J. Keirans, John J. H. Mitchell, Henry F. Moore, Michael D. Staunton. All the above candidates may present themselves for the further Examination for Honours.

Pass.—William F. Alges, Christopher Barragry, Daniel J. Barrett, Maurice J. Cogan, Samuel H. Davison, Rernard Doyle, B.A., Edmund C. Fawcett, Cecil L. Gaussen, John M. Gibson, Norman C. Graham, Gerald S. Harvey, George H. Hayes, Edward L. Garage Leckson, Lorges Lyong Loby, Lyong Lorges Lyong Loby, Lyong Graham, Gerald S. Harvey, George H. Hayes, Edward Heffernan, George Jackson, James Lyons, John Lyons, Samuel McComb, Richard McCulloch, Michael McTing, Robert C. McMillan, Ivan W. Magill, Edward W. Mann, Robert Marshall, William Megaw, Alexander G. Mitchell, Harry H. Mulholland, James O'Connor, Philip Purcell, John M. Rowe, Hugh A. Skillen, Martin Sweeney, William M. Walker, James R. White

Exempt from further Examination in Anatomy and Physiology.—Walter N. Rishworth, Thomas Smyth,

Exempt from further Examination in Practical Chemistry.—James N. Ferguson, Herbert V. O'Shea, Joseph Porter.

Joseph Porter.

The following candidates have passed the Third Examination in Medicine:—Upper Pass.—\*Henry L. Barniville, B.A., \*Richard H. Batter, Norman L. Joynt, \*Stephen A. McSwiney, B.A., Laurence P. Mulligan, Peter I. Ryan, B.A. (Those marked with an asterisk may present themselves for the further examination for Honours.)

examination for Honours.)

Pass.—James S. Bellas, William K. Calwell,
Patrick E. Carroll, Louis Cohen, Peter P. Connolly,
Pierce Cotter, Thomas A. Daly, Joseph C. Denvir,
Laurence Doyle, Francis H. Duke, Samuel R. Foster,
Michael I. Gallagher, Thomas D. Graham, Harry I'.
Hannigan, Timothy F. Hegarty, Ignatius P. Keily,
Patrick McCartan, Daniel J. MacClancy, Robert J.
McFeeters, Louis J. E. McHugh, Aloysius D.
MacMahon, Daniel McSparron, Edgar Morison, Daniel
F. Murnaghan, Daniel O'Brien, Patrick J. O'Grady,
Hugh O'Neill, James M. Rishworth, James J. Ryan,
David V. S. Willis.

#### Conjoint Examinations in Ireland.

THE following candidates have passed the First Pro-The following candidates have passed the First Professional Examination of the Royal College of Physicians and the Royal College of Surgeons, April, 1909:—J. P. English (with Honours), J. G. Atkins, J. B. Barry, W. D. Beamish, J. Cockburn, J. T. Dier, L. C. Dillon-Kelly, J. J. Elliott, D. J. Healy, D. Leahy, J. S. Levis, J. D. MacCormack, D. A. MacErlean, F. Murray, M. Murphy, J. A. O'Driscoll, T. J. O'Riordan, A. F. I. Patterson, A. T. Rhatigan, T. S. Smith.

The following candidates have passed the Second

The following candidates have passed the Second Professional Examination, April, 1909:—J. C. Attridge, J. Barrett, W. R. Beeston, U. L. Bourke, F. C. Fisher, J. Good, A. F. C. Hogg, B. Malaher, F. P. MacDermott, B. Murphy, L. J. O'Donovan, C. Petit, P. O'C. White, G. Wilson, G. Young.

#### **NOTICES TO** CORRESPONDENTS.

CORRESPONDENTS requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

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6d. per line beyond.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Ms. W. WILLIAMS.—The population of London and Greater London are treated separately in official statistics. The former is returned as having 4,833,938 inhabitants; the latter, which includes its suburbs, has 7,429,740 inhabitants. Even this latter figure does not include "The Outer Ring," for which no fewer than 2,595,802 additional must be taken into account.

than 2,595,802 additional must be taken into account.

FATAL ACCIDENTS.

Some interesting statistics will be found in the recently issued official returns of deaths during last year in England and Wales. The number of fatal accidents reported was 658. These do not, of course, include deaths of miners, which alone ran to 1,343 in 1968, nor to deaths from shipwrecks and accidents on board, from these there were 625 deaths. The total number of deaths by accident from all causes was higher than any year since registration has taken place, being 124 above the mean of the last five years. 

FOURTH YEAR (Edinburgh).—We have not seen the announce-ment, and think you must be confounding it with a work having a similar title, but by a different author.

### Meetings of the Societies, Tectures, &c.

WEDNESDAY, APRIL 28TH.

MEDICAL GRADUATES' COLLEGE AND POLICLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. A. Edmunds: Clinique (Surgical).

TRUERDAY, APRIL 29TH.

MEDICAL GRADUATES' COLLEGE AND POLICLINIC (22 Chenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical).

Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical).

Fridat, April 30th.

Rotal Society of Medicine (Clinical Section) (20 Hanover Square, W.).—8 p.m.: Cases: Mongols and Conditions that have been Confused with Mongolism: Dr. L. G. Guthrie, Dr. Sutherland, Dr. Morley Fletcher, Dr. Poynton, Dr. Langmead, and Dr. Harry Campbell. Mr. J. Jackson Clarke: Cases of Congenital Hip Disease treated by the Manipulative Method of 1904. Mr. W. G. Spencer: Reduction of an Old Subcoracoid Dislocation of Shoulder, Complicated by Fracture of Humerus, by Excavating the Glenoid Cavity. Dr. H. G. Turney: Trophædema following Trauma. Dr. Savill and Dr. P. Green: Solerodermia of the Extremities in a Woman the subject of Angeioneurotic CEdema. Mr. C. Gordon Watson: Double Infantile Coxa Vara treated by Subtrochanteric Osteotomy. Mr. H. B. Robinson and Dr. W. H. Bowen: Hereditary Transmission of Claw Hand and Foot in Mother and Child; Mother shown at the Clinical Society in 1887. 3.40 p.m.: Paper: Mr. W. Fedde Fedden: Six Cases of Infective Gangrene of the Extremities.

Royal College of Surgeons of England (Lincoln's Inn Fields, W.C.).—5 p.m.: Prof. Keith: On Specimens of Cleft Palate and Malformations of the Tongue. (Museum Demonstration.)

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Dr. J. Horne: Clinique (Ear, Nose, and Throat).

Central London Throat and Ear Hospital (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture. Mr.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Mr. Stuart Low: Accessory Sinuses.

#### Appointments.

Fells, Arthur, M.B., C.M.Edin., Clinical Assistant at the Bristol Eye Dispensary.
Flemino, James Finlatson, M.B., B.S.Glasg., one of the Medical Referees under the Workmen's Compensation Act, 1906, for the Sherifidom of Fife and Kinross, and to be attached more particularly to the Dunfermline and Kinross District.
FOWLER, TROMAS WERB, M.D.Birm., one of the Medical Referees under the Workmen's Compensation Act, 1905, for County

Court Circuit No. 20, and to be attached more particularly to Coventry County Court.

FRENCH, MARGARET DOUGLAS, M.B., B.S.Durh., Junior Assistant Medical Officer at the North Riding Asylum, Clifton, York.

GIMBELY, RICHARD HENRY, M.R.C.S., L.S.A., Medical Officer for the Ippelpen District, by the Newton Abbot (Devon) Board of Guardians, for three years.

HOWDEN, IAN DALRYMPLE CLARK, M.D. Edin., one of the Medical Referees under the Workmen's Compensation Act, 1906, for County Court Circuit No. 49, and to be attached more particularly to Dover, Folkestone, Hythe, Rommey, Deal and Sandwich County Courts.

ROBERTS, WAITER R. S., M.B., Ch.B.Birm., Medical Officer of Health for the Ongar Rural District Council.

SQUIRE, E. W., M.B., B.S.Lond., House Surgeon to the Dreadnought Hospital, Greenwich.

STEVENSON, T. H. C. M.D. State Med. Lond., M.B., B.S.Lond., D.P.H.Cantab., Superintendent of Statistics of the General Register Office, Somerset House.

THOMAS, FRANK LESLIE, M.B., B.S.Lond., L.R.C.P.Lond., M.B.C.S., Honorary Ophthalmic Surgeon to the North Devon Infirmary, Barnstaple.

Infirmary, Barnstaple.

#### Vacancies.

Middlesex County Asylum, Napsbury, near St. Albans.—Fourth Assistant Medical Officer. Salary, £160 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent. Victoria Hospital, Folkestone.—House Surgeon. Salary, £100 per annum, with board, residence, and laundry. Applications to the Secretary. York Dispensary.—Resident Medical Officer.—Salary, £130 a year, with board, lodging, and attendance. Applications to Dr. Swanson, The Pleasaunce, Heworth, York.

Lincoln Mental Hospital, The Lawn, Lincoln.—Assistant Medical Officer. Salary, £150 per annum, with board, etc. Applications to the Medical Superintendent.

Royal South Hants and Southampton Hospital.—House Physician. Salary, £100 per annum with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Down County Infirmary.—House Surgeon. Salary, £60 per annum, with board and residence. Immediate application to Dr. Tate, Infirmary House, Downpatrick. (See advt.)

The Farringdon General Dispensary and Lyingin Charity, 17 Bartlett's Buildings, Holborn Curous, E.C.—Resident Medical Officer. Salary, £100 per annum, with rooms, attendance, fire, and lighting. Applications to Thomas Darrington, Hom. Secretary.

Ingham Infirmary and South Shields and Westoe Dispensary.—

Secretary.

Ingham Infirmary and South Shields and Westoe Dispensary.—
Senior House Surgeon. Salary, £100 per annum with residence, board, and washing. Applications to James B. Wheldon, Secretary, 74 King Street, South Shields.

#### Births.

JOHNSON.—On April 20th, the wife of W. Crosby Johnson, M.B., Ch.B., Fairleigh, Pendleton, Manchester—a daughter.

#### Marriages.

FAIRBANK—OGILVIE.—On April 21st, at Christ Church, Lancaster Gate, Harold Fairbank, M.S., F.R.C.S., son of the late Thomas Fairbank, M.D., of Windsor, to Florence Kathleen, younger daughter of the late Arthur Graeme Ogivie, of Sizzwell.

GIDEON—PIZA.—On April 21st, at 118 Sutherland Avenue, Maida Vale, the residence of the bride's parents, Eugene D. Gideon, M.B., M.R.C.S., L.R.C.P., eldest son of Mr. and Mrs. D. S. Gideon, Port Antonio, Jamaica, to Ruth Jessel, younger daughter of Mr. and Mrs. Judah Pizs.

LYON-CLARK—HOLT.—On April 28th, at Rt. Mark's, North Audley Street, London, W. Lyon-Clark, of Fremington, N. Devon, eldest son of Professor William Clark, M.A., D.D., LL.D., F.R.S.C., to Neille, only daughter of W. J. Holt, Esq., of Beckwith Knowle, Harrogate.

MACKENZIE—SKEGG.—On March 12th, at the British Episcopal Church, Foo-Chow, South Chins, the Rev. Marcus Mackenzie, B.A., M.B., C.M., of the Dublin University Fuh-Kien Mission, to Ethel Florence, youngest daughter of John J. Skegg, of Sideup, Kent.

REID—CLAFPERTON.—On April 21st, at the Church of St. Marylebone, London, Archibald Douglas Reid, M.R.C.S., L.R.C.P., of 39 Weibeck Street, London, son of Dr. Douglas A. Reid, of Teaby, to Annie Alian, daughter of the late John Clapperton, of Greezock.

ROWLETTE—DAY.—On April 22nd, 1909, at Greystones Church, by the Rev. W. M. Weir, Rector of Delgany, assisted by the Rev. E. S. Daunt, Rector of the Parish, Robert James Rowlette, M.D., 42 Lower Baggot Street, Dublin, younger, son of the late Matthew Rowlette, Carn Cash, Sligo, to Gladys Muriel, eldest daughter of the late Bussel Camper Day, B.A. (Oxon.), and of Mrs. Camper Day, Liscelta, Greystones.

#### Beaths.

BEEVOR.—On April 17th, at Croxley-green, Dame Emily Georgins, wife of Sir Hugh Reeve Beevor, Bu., M.D., of 17 Wimpole Street, London, and Hargham, Norfolk, and eldest daughter of Sir William Foster, Bt., of Hardingbam, Norfolk.

CARTER.—On April 26th, suddenly, at Oskhurst, Anerley, George Roe Carter, L.R.C.S.I., aged 68.

RANDELL.—On April 22nd, at 22 Vanbrugh Park, Blackheath, Edward Benjamin Randell, M.R.C.S.Eng., L.D.S., in his 73rd year.

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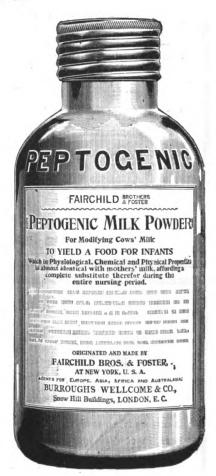
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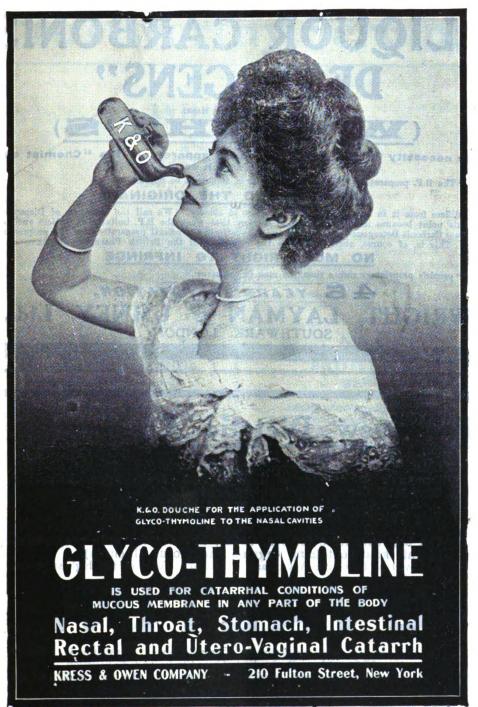
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## THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, MAY 5, 1909.

No. 18.

#### Notes and COMMENTS.

Poisons Schedule.

WE have never been much impressed with the new Poisons and Pharmacy Act, for not only was it the result of many compromises, but the Privy Council's own recommendations were

glaringly overridden in deference to the least desirable kind of trade interests. Now that the Act is on the Statute Book, any reform may be looked upon as shelved for the next decade or two at least. The absurdity of scheduling certain poisons whilst allowing patent medicines containing those poisons to escape was brought before the City Coroner's Court last week, in a case in which a woman was found by the jury to have died from an overdose of morphine taken in the preparation known as chlorodyne. There was some dispute about the actual cause of death, owing to the woman who was the subject of the inquest being a chronic alcoholic, but a toxicologist and the police surgeon were both convinced that the lethal agent was the morphine. There was a discussion as to the knowledge possessed by the public as to the composition of chlorodyne, and one of the medical men handed the Coroner a notice issued to chemists saying they were not to request purchasers of chlorodyne to sign the poisons-book, as that medicine did not come within Part I. of the Poisons Schedule. Comment on a law, especially a new law, which provides such loopholes, is surely superfluous.

Baby Smoker. THE medical inspector of the Oxfordshire Education Committee has discovered an interesting case in the course of his daily rounds. This is no less than a child not yet four

years of age who is suffering from "smoker's heart." The wretched little being is said to be supplied by his father with ten cigarettes a day, and to exhibit his accomplishment at local shows for the edification of gaping yokels. We are glad to learn that the Education Committee are We are going to hold an inquiry into the case, as not only are its pathological features worthy of investigation, but the conduct of the father, if what is said of him is true, is so inhuman that the Society for the Prevention of Cruelty to Children might well turn their attention to it. Dr. Kerr has already shown in his reports what effects cigarette-smoking may have on children, but we do not remember that any case of a mere baby has ever been brought forward in connection with tobacco-poisoning. The effect, however, is notoriously more marked in the young than in adults, and whereas large numbers of grown people habitually exceed moderation in smoking cigars without ill effect, a very few whiffs are generally enough for the most hardy school-boy.

In the instance under notice it would hardly be surprising if something more than temporary derangement of the cardiac action ensued.

Medical Motorists. MEDICAL men must not count on the precedent recently set by the Kingston Bench in the case of Mr. Stansfield Collier, the facts of which will be fresh in the minds of readers. A

Middlesex surgeon, travelling to Hampshire to an urgent operation, was timed by the police to be travelling in his motor at twenty-five miles an hour in the neighbourhood of Godalming, and was summoned to appear before the magistrates. gentlemen held that the safety of the public was of greater moment than the safety of a single person, and inflicted the usual fine. We confess there is a great deal to be said on both sides, and we should be the last to ask that unrestricted freedom should be given to medical men to travel at any rate they thought fit on the plea of professional exigency. Every case should be considered on its merits, but if a medical man can show that he is proceeding to a grave emergency, such as arterial hæmorrhage, poisoning, or obstetrical accident, and that he was not jeopardising the lives of others, we think that the Bench should consider such facts as providing a valid excuse for a reasonable excess of speed. Such cases are, happily, comparatively rare, and would only occasionally be brought to notice. The natural dislike of medical men to have to appear in the public court, to pay costs, and to lose valuable time, would be sufficient deterrents from abuse.

Reading for

WHAT is suitable literature for the sick? The question is suggested by the pronouncement of a medical man the Sick. that incalculable harm is often done to patients by reading "exciting and jarring novels." Especially to be condemned are

stories which "excite the imagination or leave too much to the imagination." We are all agreed that it is the height of unwisdom for patients suffering from heart disease to read exciting and jarring novels, but we cannot say that we think books which leave a good deal to the imagination are to be barred in all cases. The plea would seem to be one for "realistic" literature, which is generally a euphemistic term for a particularly unhealthy variety of novel. The authority quoted, however, does not leave us in doubt, for he plumps for "humorous stories written in a sentimental vein." The humorous stories that we know are not sentimental, and the sentimental are only humorous in their fatuity, with, of course, the immortal exception of Dickens. The sick, then,

would seem to be left nothing but Dickens, and as fashionable modern sentiment professes to find that classic as insipid as it pronounces Mozart's music, this reading would be as unpalatable to them as their broth and milk. Perhaps, after all, when a man is ill it is as well to let him read what he finds interesting, for not infrequently he finds devotional literature more to his taste even than humorous stories written in a sentimental vein.

A suggestive article appeared some weeks ago in M.A.P., a journal that **Empty** always speaks sympathetically of Pockets. the medical profession. It was written by the lady who writes the "Woman's Note-book," and is entitled "Working Pockets. for Nothing." At the outset she remarks that it would be easy to fill more space than that at disposal were she to write an article on "A Modern Doctor's Empty Pockets." Will doctors ever Will doctors ever strike? she wonders, and thereby repeats in essence a question that has vexed the medical world more or less pointedly for the past two generations. For what is a strike except the reduction to practice of a general organisation to reduce grievances? But the organisation is a necessary preliminary, and at present even the largest of our professional bodies has not placed upon its programme defensive protest, or, for that matter, even simple elementary defensive measures. When the strike comes-if we may judge from the signs of the times—there will be no lack of subjects to protest against, sweated contract practice, the competition of midwives and of hospitals, the existence of a non-representative and non-elective General Medical Council with full disciplinary and defensive functions, and the chaos of the many-portal system of qualifications. If medical men are to strike, these are only a few of the things they may legitimately strike about.

Telephone

M.A.P. deals with things within Consultations. her daily experience—and asks if the doctors will strike for fees for telephone advice? There are both men and women, she thinks, who are not only full of fear and anxiety of every sort for their loved ones at home, but who think it far cheaper—as, indeed, it must be-to ring up a doctor than to ask him to come round. Among other grievances, some of them obviously impossible to strike against, the

But the non-medical writer in

writer speaks of the necessity of appearing prosperous, of time taken up in unremunerative hospital work, of the "frauds" who seek hospital advice gratis, although able to pay for amuseof the doctor's friends who expect to be treated for nothing, of the charity cases thrust upon every medical man wholesale, and, lastly, of the week-ender at seaside hotels who departs on Monday without paying his fee. This list, by its very incompleteness and inadequacy, is interesting, inasmuch as it sets forth some of the drawbacks of professional life as they appear to a sympathetic journalist from the outside.

#### LEADING ARTICLES.

MEDICAL RESEARCH DEFENCE.—II.

THE extremely good and philosophical evidence given by Lord Justice Fletcher Moulton before the Royal Commission on Vivisection forms one of the not least important parts of the publications of the

science is not the bungling, haphazard sort of thing that the world outside believes it to be is pertinent to the last degree, although, at the same time it cannot be denied that a great number of scientific discoveries are, at the least, of vicarious, if not fortuitous, origin. It would be hard to find a better working definition of science as "common sense enlightened by appeals to actual fact, which are framed for the express purpose of giving you the information which is necessary for your common-sense to act upon." The realisation of this meaning throws a flood of light upon many phases of the subject. A man who experiments upon himself may be performing an heroic actionbut it may, nevertheless, be argued that he is a bad scientific man if he be driven to take such a course. The method that has hitherto yielded the most brilliant results has been to test theories and to ascertain fresh facts experimentally with the minimum of suffering to lower animals and without endangering human life. If the scientific man be impatient, he would like, perhaps, to experiment upon himself or upon other men, but if he be patient, there is no need that he should do anything of the kind. This attitude, of course, assumes that man has the same right over the lives of the lower animals that he claims for other purposes, such as that of food, of clothing, and even of the baser one of the mere provision of sport. Then, again, Lord Justice Moulton put very clearly the point which answers the unceasing argument of the anti-vivisectors, that the Act of 1878 has not restricted experimentation, inasmuch as the number of experiments since that year has increased tenfold. In order to arrive at the truth, a distinction must be drawn between really painful experiments and inoculations performed for diagnostic purposes, that is, to ascertain the nature of diseases in order that we might fight them. "The greater number of the experiments," he says, "have been inoculations, and as soon as the disease is developed the animal is killed, because what the experimenters have wanted to find out, aye or no, was what would the disease be under such circumstances? The number of cases in which you have to allow really painful experiments is confined to these-that is, the cases where you are examining the distant effects of certain lesions of the nerves, of interference with the digestive organs, in order that when you see symptoms which are so produced you may know where the evil is. They are never, I think, performed casually. The very painful ones would always, I should think, in the history of English research in physiology, be performed for some very definite object in order to give us this very essential knowledge." Turning next to a contribution by Professor Starling, of University College, we find a practical account of the use of dogs in scientific experimentation. It so happens that the dog is one of the few animals that can be kept in a healthy and normal condition in or near a laboratory, which, from the nature of the case, is usually fixed among populous surroundings. The dog is practically almost as omnivorous as man himself, while its organs are not too small to permit of experimental interference. Practically the whole of our knowledge Research Defence Society. His remark that I of the production of lymph in the body has been

derived from experiments upon dogs. This is owing to the fact that the main lymphatic ducts are "too small and delicate in the cat and rabbit to permit of a tube being placed in them so as to measure the lymph produced under any given circumstances. With the exception of some of the earliest observations made upon calves, our knowledge of the causation of the heart sounds, of the pulse, of the facts of blood pressure, has been derived from experiments upon the dog, the only animal of sufficient size obtainable for the purpose"; and to this Professor Starling significantly adds: "Further extension of our knowledge in these matters can only be looked for by continuing the experiments on dogs." Much the same may be said of the study of intestinal movements." Professor Schäfer's important experimental researches upon artificial respiration were carried out solely upon the dog, "since this was the only one of the laboratory animals in which the bony cage of the chest can be compared in any way with that of man." Then, again, the dog is the only animal fitted for an artificial gastric fistula, a condition that has yielded information of inestimable value to the physiologist, the pathologist, the physician and the surgeon. Professor Starling points out that, first of all, the operation involved is carried out under an anæsthetic; secondly, that wounds in man are not painful unless they become septic. By the terms of the certificate under which experiments are made, if the antiseptic precautions fail and suppuration occurs, the animal is required to be killed under an anæsthetic. The healed gastric fistula itself is painless. Even under these circumstances, we are practically prepared for Dr. Starling's emphatic statement: "Though I have been engaged in the experimental pursuit of physiology for the last seventeen years, I can say that on no ocasion have I ever seen pain inflicted on a dog or cat in a physiological laboratory in this country, and my testimony would be borne out by anyone engaged in experimental work in this country." In conclusion, a word may be said of the extinction of Malta fever, tersely described by Sir David Bruce, the distinguished discoverer of the specific microorganism, the micrococcus melitensis. It is due to experimental methods pure and simple that the disease has been eradicated and Malta converted from an unhealthy to a healthy station. During the past twenty years 14,000 or 15,000 British soldiers have been attacked in that island. A more triumphant vindication of experimental research it would be hard to find than that contained in the history of the extinction of Malta fever. But the publications of the Research Defence Society constitute one long series of similar vindications. It is well that experts, in reasoned thought and exposition, should be brought forward to inform the public with authoritative voice what are the answers to the charges of inhumanity which have for many years past been made against men of high aims and noble intellect engaged in the front rank of scientific warfare. Mr. Stephen Paget may be congratulated upon the share he has had in the organisation of the Research Defence Society upon lines that are, happily, not less defensive than educational.

DMMCTD ATION OF AN DOTTION

ADMINISTRATION OF ANÆSTHETICS. A MATTER of great public importance is raised by the Bill now before Parliament to regulate the administration of anæsthetics. The classes, apart from the general public, who will be chiefly affected by it are medical men, registered dentists, and quack dentists, and the principle involved is one deserving of the most careful consideration. Originally it was intended to enforce by Act that only registered medical men should be allowed to give general anæsthetics, but, owing to the opposition which would certainly be raised by dentists, the promoters have decided to put in a clause exempting them from the prohibition. Now, although anæsthetics may occasionally be administered to patients by medical quacks and bone-setters of one kind and another, we do not believe such practice is at all common, and consequently the Bill comes to be directed almost entirely against irregular dental practitioners. On the other hand, there is a strong party which would have registered dentists included in the ban, and a proposal to this effect will almost certainly be brought forward, so that we have to consider two points, namely, whether it is desirable in the public interest that registered dentists should be excluded from administering anæsthetics, and, further, whether dental quacks should be prohibited. The two cases stand on different footings. As regards the general question, there can be no possible doubt that, ideally, no person should be allowed to administer a general anæsthetic who has not been trained in clinical medicine and surgery. A dentist, per se, is not so instructed, his general medical training being purely theoretical, and specialised with a view to his future craft. Dentists, who are not also medical men, can have no scientific knowledge of the effects of an anæsthetic, and no rules, other than rules of thumb, to guide them in their administrations; whereas, not only are all the vital processes profoundly affected by the inhalation of an anæsthetic gas, but the clinical signs exhibited by the pulse, respiration, and so on, which are the sole guides of the medical man, can represent nothing concrete to a man who is not intimately acquainted with the clinical phenomena of the body in health and disease, and skilled in interpreting physical signs. Moreover, to cope with emergencies which arise during the time a person is unconscious from an anæsthetic demands readiness, resource, and surgical skill. The anæsthetist must be capable of judging whether the condition of disturbance is due to over-dosage, to cardiac or respiratory failure, to obstruction to the air-passages, or what not, and he must be prepared to inject strychnine, to give amyl nitrite, to perform tracheotomy, to do artificial respiration, or whatever is required, with promptness. On his judgment the fate of the patient hangs and the moment for successful intervention rapidly passes. Even the elementary precaution of examining a patient's heart before giving an anæsthetic cannot be undertaken without long medical training. People who talk about deaths under anæsthetics forget the number of deaths which are averted by withholding anæsthetics, by judiciously choosing the proper anæsthetic for patients in impaired health, and by the success of the anæsthetist's intervention

when emergencies arise, not to mention the thousands of cases in which the anæsthetist is warned by his observations of an impending change in the patient's condition, and adopts suitable precautions to prevent disaster. Now, as dentists, from the nature of their training cannot possibly possess this skill, it is obviously undesirable that they should be allowed to give general anæsthetics. It will be replied that they seldom give anything except nitrous oxide, that nitrous oxide is safe, and that if they are prohibited from giving it, medical men will have to be present at all their operations, with great consequent increase in the cost to the patient. We agree, and we agree also that the question is one for the lower middle classes and the poor who do not go to hospitals. Well-to-do people practically always insist on having gas from their own doctor, as it is. We are certain that no dentist should be allowed to give chloroform, ether, or, indeed, any anæsthetic except gas, but we think it ought not to be impossible to arrange that they were instructed in the use of gas, and allowed to give it, though we fail to see how they could be expected to cope with surgical emergencies, such as obstruction of the larynx, occurring during its employment. The Bill would practically give the coup de grâce to the quack dentist, and we do not think there are any reasons of public policy why his departure should be mourned. Temporarily, in poor districts, a certain dislocation would follow his disappearance, but competition being what it is, the fees of registered dentists would soon accommodate themselves to humble pockets, and the poor would be sure that those who practised on their mouths would not, through ignorance, commit the awful blunders which are far too common at the present day. The criticism of the Bill is meeting with at the hands of the lay papers is characterised by the usual gross lack of information which is associated in the lay mind with all things medical. Perhaps, however, the abysmal depths of ignorance were plumbed by an article in the Evening Standard of April 29th. In a leading article that journal set forth that twelve menths ago one of "our leading coroners" and a 'surgeon of European renown" came into collision on the question of holding inquests on persons who died under anæsthetics! That would be a bad enough blunder for one article, but the writer goes on to speak of a "sprinkling of dangerous quacks" being at the bottom of the medical pro-fession, who would be restrained by the Bill. If there are "quacks" anywhere in the profession, they would not be in the least affected. Sailing gaily on to defend the "unregistered dentist" (whoever he may be), the writer makes out that it would be hard on him and his patients if a qualified doctor had to be present when he gave an anæsthetic! As if any qualified doctor would be allowed to give an anæsthetic or countenance its administration by an unregistered man. But the gem of the article we have reserved to the last. We give it without comment, lest we impair its delicious confusion of ideas:—"It is a mistake to suppose that as an aid to the surgeon they (anæsthetics) first came into existence and use fifty years ago, when Lord Lister (sic) made his first amputation under ether at University College Hospital"! For the rest of the ridiculous nonsense set forth by our contemporary space fails us.

#### CURRENT TOPICS.

#### Escapes from Lunatic Asylums.

THE problem of the escaped lunatic is one that concerns the safety of the community, and its due consideration is the bounden duty of the State, in whom the care of lunatics is ultimately vested. The official attitude of the responsible authorities in the House of Commons must at times appear to the uninitiated outsider to be a trifle flippant and bureaucratic in dealing with a matter that is vital to the safety of the citizen. What guarantee is there that most lunatics who escape from asylums, and are not recaptured, are not of a dangerously criminal or homicidal tendency? Certainly the statistics given by Mr. Gladstone in the Commons a few weeks since are far from reassuring. The official figures relating to the escape of lunatics from asylums in England and Wales were as follows :-

Year.		Escaped.	Recaptured.	Still at large.
1904		367	327	40
· 1905	1	363	328	35
1906		396	349	47
1907		356	317	39
1908		364	308	56
Five years' aggregate		1,846	1,629	217

In answer to a further question, the Home Secretary replied: - "The Lunacy Commissioners consider, and I agree, that asylum authorities generally in the country take proper precautions to prevent escapes. As they state in the report which was presented to Parliament last week, public opinion would not endorse a retrograde step of making asylums once more in the nature of prisons." This hardly appears satisfactory to the taxpayer who has to face the consequences of the escape, both immediate and remote. As a famous writer upon social economics puts it, the Lunacy Commissioners appear to be thoroughly satisfied with the addition of one escaped lunatic per week to the free population, and to the subsequent multiplication of lunatics which follows. To differentiate between an asylum and a prison is surely to beg the question. Mankind has long ago decided that animals and lunatics require restraint in the best interests of the community. If restraint is to be efficient, it must be enforced and maintained just as stringently in the one case as in the other. Perhaps a departmental inquiry would help us to arrive at some conclusion with regard to the important question of escaped lunatics.

### The Taxation of the Motor-Cars of Medical Men.

A SHORT time ago we drew attention to the fact that the National Telephone Company, in their new system of charges, classified medical men in the same category as shopkeepers and business men generally, with the result that they were called on to pay a considerably higher annual charge for their telephones than were so-called "private" individuals. We are glad to think that our objections to such a course had some effect, and that the Company—in Dublin, at least—have not compelled medical men to change from an unlimited to a measured rate system. We now take the first opportunity of directing professional attention to one of the proposed clauses of the new Budget,

whereby a tax of three pence per gallon is to be imposed upon petrol. As at present proposed in the case of "commercial users" and motor-cabs, a remission of half this sum will be given. We have, however, some fear that while the Telephone Company, for the sake of an increased revenue, classified medical men as "commercial," the Government, with a similar object, will classify them as "private." If, however, a united demand is presented by the medical profession for the right to obtain petrol at the commercial rate, we have no doubt that it will be successful. As to the wisdom of the tax in general, we say nothing, except that we should like to be able to forecast the opinions of posterity on the action of the Government in hampering, by taxation in its childhood, a mode of locomotion which, if unhampered, promises to be of universal application in the near . . .

Mental Obliquity.

A CORRESPONDENT has sent us a copy of a most curious article on fevers which he has apparently contributed to the columns of a local paper, and which he requests us kindly to reprint. We regret we are unable to comply with his request, but we gladly notice his production, because it affords a curious insight into the popular mind, which is so prone to suffer fools gladly. The article begins with the statement that "truth and error, fact and fiction, cannot occupy the same place in thought. . . . There is thought that enters easily, thought that enters with difficulty, and thought that never enters at all." The writer then proceeds to inform his readers that "after thirty years of hard work and stern thought, I have evolved my nerve current theory... This theory implies that the vital force is a fluid which circulates through the system by means of the nerves, in the same way that the blood circulates by means of the veins." Starting with this theory, he then proceeds to elaborate his "theses on illness." This "theses" consists of some fifteen dogmata, the essence of which is that "the circulation of the vital fluid by means of the nerves is the true key to the knowledge of the nature of disease," and that "this discovery is more important and far-reaching than Harvey's discovery." Although each "thesis" might form the heading of a distinct chapter, the writer is conscious that the editor will "cut him short," and accordingly he abandons his dogmata, and proceeds to the discussion of fevers! "A fever is a rumpus. It is the vital force making a desperate effort to expel the excrementitious matter from the system. It is a sign of health. We ought to rejoice to see a fever." "There are almost no fevers to-day, and chronic diseases are rampant." This is the writer's "saddest reflection." Hence the presence of sickly children in our schools and the degeneration of the race. He concludes his article with the sigh, "Oh, si sic sil." Surely none but a most matter-of-fact editor could have omitted the last two letters, which are so very obvious. In later articles the writer proposes to tell us how to substitute fevers for chronic diseases.

#### PERSONAL.

DR. JOHN SHEPPARD has been appointed a Justice of the Peace for the Borough of Dublin.

DR. LYTTON P. MAITLAND has been appointed Medical Registrar to Charing Cross Hospital.

THE British Balneological and Climatological Society will hold its annual provincial meeting this year at Torquay, the date being fixed for Saturday, May 8th.

THE next session of the General Medical Council will open on Tuesday, May 25th, when the President, Sir Donald MacAlister, K.C.B., will take the Chair at 2 o'clock, p.m.

THE Right Hon. Lord Viscount Duncannon is to preside at the Festival Dinner in aid of the funds of the Metropolitan Hospital at the Whitehall Rooms on May 20th next.

SIR CHARLES BALL, Regius Professor of Surgery in the University of Dublin, will deliver a special lecture on "Cancer of the Rectum" before the Post-Graduate Class to be held early in June.

At the meeting of the Therapeutical and Pharmacological Section of the Royal Society of Medicine yesterday Dr. Hale White and Dr. Eyre opened a discussion on the subject of "Vaccine Treatment."

DR. E. W. HOPE, the well-known Medical Officer of Health for Liverpool, has been presented with a handsome testimonial by the members of the Municipal Sanitary staff on the attainment of his silver jubilee in the service of the Municipality.

LORD SANDHURST, treasurer of St. Bartholomew's Hospital, has received from Mr. Henry T. Butlin, D.C.L., F.R.C.S., £100 towards the pathological block, being a third donation of that amount to the rebuilding fund of the hospital.

At a provincial sessional meeting of the Royal Sanitary Institute, which will be held at the University of Birmingham on Saturday, May 8th, a discussion on Tuberculosis and the Milk Supply will be opened at 11 a.m., by Mr. J. Malcolm, F.R.C.V.S., Veterinary Superintendent to the Birmingham Corporation.

THE Hon. Harriet Le Poer Trench, who left estate valued at £122,769, bequeathed the net proceeds of the sale of valuable personal articles to the Hospital of St. Elizabeth, St. John's Wood, and on the falling in of certain annuities the capital is to be paid to the hospital, her intention being that the bequest to the hospital shall amount to £10,000.

MAJOR F. J. W. PORTER, R.A.M.C., appeals for funds in aid of the Princess Christian Mission Hospital at Sierra Leone, which was totally destroyed by fire on March 17th. Owing to the heroism of Miss MacPherson, one of the nursing sisters, no lives were lost, but the European and native sisters had the whole of their effects destroyed. Subscriptions may be sent to Mr. F. Fishwick, honorary treasuren, Sierra Leone Diocesan Fund, 20 Harold Road, Upper Norwood, S.E.

THE Ninth Annual Dinner of the Medical Graduates' THE Ninth Annual Dinner of the Medical Graduates' College and Polyclinic will be held at the Trocadero Restaurant, Piccadilly Circus, on Monday, May 24th, at 7.15 for 7.30 p.m., when Professor Howard Marsh, M.A., M.C., F.R.C.S., Professor of Surgery in the University of Cambridge, will preside. During the evening a presentation will be made to Captain A. E. Haward Pinch, late Medical Superintendent of the Polyclinic. The price of the dinner, 7s. 6d. (exclusive of wine) will be collected during the evening.

### A CLINICAL LECTURE

#### THE DIRECT OR INDIRECT EFFECTS OF SURGERY OR SURGICAL LESIONS IN MENTAL OR NERVE DISTURBANCES.

By WILLIAM ALEXANDER, M.D., F.R.C.S.,

Hon, Surgeon, Royal Southern Hospital, Liverpool; Lecturer on Clinical Surgery, Liverpool University.

THE influence of the different states of health or well-being of the various organs of the body on the mind is admitted by everyone. The genial influence of a comfortable dinner, the mental irritation produced by want of one, or by an indigestible meal, the angry feelings and violent expressions which often angy reenings and violent expressions which often accompany gout, the misery of toothache, ear disease, or neuralgia, the despondency born of constipation or liver disease, and the acute delirium of fever or of sepsis, are only a few of the most common phenomena that with many others lie within the observation not only of the trained observer, but also of the man in the street. We have heard of people being driven out of their wits by tickling, and the delirium at the period of the greatest distension of the cervix uteri or perinaum is really a short madness produced by the severity of the symptoms. The last days of inoperable cancers of the tongue and of the breast I have several times seen clouded by a marked attack of delusional insanity, and I can recall several operations where with a normal pulse and temperature the patient was quite insane for some days after the operation, and I can also remember two where the patients died in consequence of the exhaustion produced by the mental disease and by the impossibility of satisfactorily feeding the demented patients. These are general, well authenticated cases about which we are all agreed, but the cases which I wish to bring before you today are not these general cases. to bring before you to-day are not these general cases, but others where disease either functional or organic, of a solitary organ or of a definite part of the body produced symptoms of insanity, mostly of the delusional type, and where the removal of the disease cures at the same time the insanity. I shall first of all briefly relate the cases, then distinguish them from other nervous cases where operation should not be performed, and finally point out to you the dis-tinguishing features of the class of cases where I think

tinguishing features of the class of cases where I think operations are likely to be beneficial.

CASE 1.—Twenty years ago I excised very extensively the left knee-joint, for advanced tubercular disease, of a man, at. 25. After operation the limb was firmly fixed in an arrangement of Thomas's splint and plaster-of-Paris that allowed free access to the knee and at the same time maintained. to the knee and at the same time maintained perfect rest of the limb during each dressing. These dressings had to be done daily on account of the septic conditions of the parts operated on. The pulse and temperature kept satisfactory all through the course of the case, but five days after the operation the patient became "insane." Each morning he would describe imaginary morning trips to the local market extensive became "insane." Each morning he would describe imaginary morning trips to the local market, extensive purchases of cattle there, the friends that he had met and the conversations he had had with them. He enjoyed telling me about these trips of his, talked with vigour and intelligence, and laughed at the funny parts in a perfectly natural and apparently rational manner. With the nurses he was lively, pleasant, and full of the same delusions, which he would describe to them in the same circumstantial way which he did to me. He never complained of any pain, and there to me. He never complained of any pain, and there was no evidence of any undue pressure. A fortnight after the operation I took down the limb and found a small pressure sore of the size of a shilling on the heel. While I was taking the plaster off he told me where he had been that morning. Next morning when I visited the patient all the delusions had completely disappeared, and he was surprised and puzzled at my questions in reference to them. He only remembered them as the shadowy figments of a dream. It may be said that the intolerable agony of the constant

pressure upset the mental balance in this case. of that agony there was no evidence. He seemed to be, and always said he was, comfortable, and there was no indication of discomfort at any time. It must have been some peculiar mysterious result of the pres-

Insanity is rare from pressure sores. This is the only example I have met with where any mental symptoms occurred, and I have seen a good many

pressure sores in my time.

We could not say how long it was after the removal of the splint before his mental balance was restored. It was only next morning that my questionings found it out. No other change had occurred in food or medicine, the only change was the removal of the pressure on the heel.

CASE 2.—In November, 1907, a boy, æt. 14, the subject of a swing-boat accident, was admitted under my care suffering from a depressed fracture of the skull. The depression was situated a little to the right of the middle line and two inches in front of the occipital protuberance on the right side. The boy on admission was confusedly maniscal shouting incomplete the state of the s admission was confusedly maniacal, shouting incoherently, rolling out of bed in a sub-conscious state, with flushed face and suffused eyes. He had no temperature. The accident had occurred three days before he came under my care, and he had been taken to a neighbouring hospital on account of the cerebral symptoms. The father said he was advised to have the boy sent to a lunatic asylum, as no operation could be performed until he became calm and rational. could be performed until he became calm and rational. The night of his admission to my wards I operated and raised the depressed bone, a sharp-pointed piece of which had penetrated the superior longitudinal sinus. By raising the head and packing the wound firmly with double cyanide gauze, serious hæmorrhage was effectually prevented. The boy was quite rational next morning, and remained so during his convalescence, and we know he has continued well, as we have seen him frequently until quite lately, i.e., six months after operation. six months after operation.

REMARKS.-I removed the depressed bone immediately because it was manifestly pressing on the brain and was the probable cause of the mental excitement. My predecessor in the case did not perceive any causal connections between the mental symptoms and the traumatism, and advised asylum treatment before operation. It is quite likely that the cerebral symptoms would have subsided under expectant treatment, as the brain would in time have become accustomed to the new condition of matters, but the short and straight course was, it seemed to me, to remove the offending body, when the cerebral symptoms would probably disappear of themselves. The boy was quite sane till the bones of his skull were crushed in, then he became maniacal. The bones were removed from their depressed position, the brain rose to its original position, and the mental dis-

turbance disappeared.

CASE 3.—In the beginning of May, 1899, nearly ten years ago, I was asked to see a young lady, æt. 26, with Dr. Gill at his asylum at Formby. The case was one of delusional insanity with suicidal tendencies. Her father had died by his own hand. The object of my visit was to ascertain if the patient suffered from any uterine disease, as was alleged by her friends, the cure of which might relieve the mental condition. We examined the patient under an anæsthetic, and found that she was suffering from a marked retroflexion of the uterus, which had probably existed for a long time. We were told that the patient

had complained of pains in the back, and "bearing down" for some years. After considering the case carefully and anxiously, we agreed to recommend operation. Both the patient, who was fairly lucid at the time, and her mother were pleased to find that something was wrong that might explain the disturbance of the mental state, and preparations for the operation were at once made, and the operation of shortening the round ligaments was performed in the asylum. It was quite successful in every way. The It was quite successful in every way. wounds healed by first intention, and the state of the patient's mind gradually became quite natural and sane. About three months after the patient was dis-charged cured. She has remained well ever since, and has been actively engaged in work that occupies and tries all her faculties. The alternative of operation was treatment by pessaries, and at the time of the examination we had pessaries ready for insertion; but we preferred an operation on the ground that it would be better to avoid instrumental treatment that might, and probably would, require frequent manipulation, and to advise a treatment whereby the dis-placement would be cured once and for ever. The result in this case equalled our highest hopes, and the length of time since the operation shows that the good results have not been ephemeral.

Case 4 occurred in an epileptic woman, æt. 32, who had been a confectioner until the onset of fits compelled her to give up work and take refuge in the epileptic colony at Maghull. Here she showed signs of increasingly severe attacks of menorrhagia accompanied, and sometimes followed by periods of such extreme irritability and violence towards her companions, that her mother was at last called upon to remove her daughter from the colony. The poor woman was in great distress. She could not keep her at home as she was afraid of her; she disliked the idea of sending her to a workhouse, and the patient was so sensible and affectionate in the intervals of her irritable state that she could not think of abandoning her to such surroundings or to those of a lunatic asylum, which we feared would be her final home at no remote period. She was advised that the mental condition was probably due to the state of the endometrium, and that if this were cured, the hæmorrhages stopped, and the state of anæmia corrected, the mental condition would improve so that we might be able to retain the patient at Maghull. Curetting had already been performed several times without any permanent good effects, and ergot and other remedies had been tried in vain. The only certain remedy was hysterectomy. This would stop the menorrhagia effectually, and the question of marriage need not be considered if the mother and child were both willing. The continuance of the race through the patient would not, under any circumstances, be advisable. Both mother and daughter not only consented, but begged that the operation should be performed. The operamother and daughter not only consented, but begged that the operation should be performed. The operation was successfully performed by the abdominal route twelve months ago. Since the operation the patient has improved very remarkably, not only as regards her physique, but her mental condition is so much improved that she is now a good colonist and lives at peace with her companions. She is receding rapidly from the borderland of insanity.

CASE 5.—A lady, et. 55, was troubled with intense intercostal neuralgia on the right side, so intense as to induce a melancholic condition and to cause the patient to cry out frequently and become bathed in tears. She had a diffused fatty tumour located in the

patient to cry out requently and become bathed in tears. She had a diffused fatty tumour located in the interscapular region on the affected side, and this tumour, in my opinion, was the cause of the neuralgia, and the best treatment was, from any point of view, obviously the removal of the lipoma. The patient did not like the idea of an operation, and being in London she consulted a recognised authority of the very highest position, who informed me by letter that the neuralgia was, he believed centric in origin, due to some obscure affection, probably of the posterior spinal nerve roots or of the spinal cord. The fatty spinal nerve roots of of the spinal reverse roots. He had never seen such tumours produce pain, and he prescribed a nerve tonic, containing arsenic, to be taken for a long time. Several other opinions were obtained, all practically agreeing with this. Well, I

said to the patient, I must bow to the weight of authority, and your best plan will be to take the medicine regularly as directed; but, I said (it was now July) "if at the end of the year you are still in despair, if you come to me again I will have no hesitation in removing the tumour." In November she came back and said she placed herself in my hands, that her condition was no better and was intolerable. that her condition was no better, and was intolerable, and that if I still thought the operation likely to cure her she was prepared to undergo it. The operation was performed on December 30th, 1891. About half a pound of fatty tumour was removed from the back, the aponeuroses and fasciæ over and between the dorsal muscles had to be opened up to allow of the removal of masses of fat that had penetrated the muscular interspaces, and had burrowed in all directions. I was rather appalled at the unexpectedly large gap that I was compelled to make before the whole tumour was removed and feared the immediate result of such an extensive dissection as was found to be of such an extensive dissection as was found to be necessary. However, the shock was not severe, and the wound healed quite satisfactorily. On the fifth morning when I visited the patient I found her in tears. She said she was "just as bad as ever," and that I was wrong in thinking the tumour had anything to do with the neuralgia. I asked her to give me a short time longer before my practice was quite condemned; that we had disturbed the nerves a good deal, and that we could hardly expect them to settle down so soon. She agreed to keep up her spirits for down so soon. She agreed to keep up her spirits for another week. On the 7th day, i.e, two days after, she received me with a radiant face, saying that she she received she was losing the neuralgia, and that I was right after all. To make a long story short, she was quite cured of her neuralgia, and remained well until her sudden death from cerebral hæmorrhage seven years afterwards.

Now, gentlemen, these cases offer some instances, which I could add to if I searched my notebooks, but they are sufficiently varied to represent several classes

of disease.

(1) The mysterious effects of pressure on the heel in producing insanity, and its immediate cure when the pressure was removed.

(2) The direct effects of a depressed fracture of the skull on the onset of acutely maniacal symptoms and the immediate relief through the elevation of the depressed bone.

(3) The presence of a retroverted uterus in a case of delusional suicidal insanity, and the good effect of the cure of the displacement on the insanity.

(4) The baneful influence of metrorrhagia on the

mental state and the probable rescue of the patient from a lunatic asylum by operation.

(5) The failure to connect as cause and effect a lipoma of the back and intense intercostal neuralgia, and the complete cure of the patient by operation.

You will find gentlemen, as you engage in the work of your profession that the above cases are rare, and that there is a large amount of scepticism amongst medical men as to the connection between the alleged operations and the accompanying nervous or mental operations and the accompanying network of mental disease. Some ladies who were acquainted with the history of the Case No. 3, had a relative similarly affected, and believed, whether rightly or wrongly, that she had also a uterine displacement. They tried that the displacement of the displacement of the control of the displacement of the control of their utmost to have their suspicions verified or disproved by a vaginal examination, but it was impossible; the opinions of the medical attendants (specialists in lunacy) were so strongly against the possibility of such a condition that the patient was enabled to commit suicide without any examination having been made to find out her condition. The reason is that we know so little about the nature and causation of mental disease that, to use a term from the billiard room, such cases as I have described are put down as "flukes," and you know that flukes are not to be reckoned on as regular occurrences. Uterine displacements, as a rule, occur without mental disturbances, pressure sores rarely produce delusional insanity, and a depressed fracture of the skull does not often produce acute mania, although I have met with several cases where it did. It is not, however, the general experience.

Pure physicians generally look upon such people as neurotics, and talk about the mysteries of hysteria and neurasthenia.

Many years ago a bright little woman was brought Many years ago a bright little woman was brought to me suffering from severe pelvic pain, enlarged ovaries and retroflexed uterus. The displacement was corrected, and change of scene obtained, but without any improvement. A physician was called in, and the disease declared only neurasthenia, and a proposed exploratory laparotomy was negatived, the statement being made that if the woman was left alone she would be all right. Eleven years after she called on me, bringing another patient, and I had an opportme, bringing another patient, and I had an opportunity of ascertaining her condition. The pain in her pelvis and back was worse, but she dare not complain as her husband immediately thought she was malingeras her husband immediately thought she was malingering, and would not allow her to see any doctor. She did not call down "blessings" on the head of that physician, whom she looked upon, and rightly, as the bane of her life and the cause of her misery. Now, many cases apparently somewhat similar to those I have described to-day will be found amongst the hysterical or neurasthenic people with unstable nervous systems, who are likely to be upset by apparently trivial causes. Such people are often very fond of operations, and sometimes desire very serious operations to cure their symptoms, and sometimes a skin wound does just as well as the full operation and occasionally cures the patient of an imaginary pain or of an imaginary disability. These are quite different of an imaginary disability. These are quite different to the cases I have described, and are rarely benefited by operative treatment. One remarkable case of this neurasthenic kind was seen by me nearly twenty years ago, where the patient, a male, æt. 30, about to be married, complained cf great pain in a varicoccele. This I operated on in the usual way, and he was quite comfortable till the wound healed up. Then the pain returned as before, and he went to another surgeon, who took away some veins from the inguinal canal. This succeeded till the wound again healed. He went to another surgeon, and had the whole tract of the cord cauterised with the same final result. After a varied experience during ten years of surgeons by operative treatment. One remarkable case of this After a varied experience during ten years of surgeons in Liverpool and London he returned to me, and I cut down on tender points with immediate, but temporary, relief, until at last I refused to cut him any-

where again.

Cases like this you should avoid meddling with. This man blamed us all in turn and described the mistakes that each of us made, the last operator being for the time the scapegoat for the sins of all the others. The first operation for varicocele was the only legitimate one; the others were unnecessary and harmful. Another case, male, æt. 40, whom many of you may have seen in my wards, complained of intense pain in the left groin and testicle of such an agonising nature that he could not work at his trade as a joiner without "tremendous" discomfort, and yet he said he must work as he had an old mother depending on him. Recognising the neurotic nature of his pain I advised him to continue work, as it was, to my mind, his only hope, and gave him nerve tonics and encouraging advice if he fought on in spite of the

Whether by his own fault or no, he was thrown out of work, and he begged me to take him into hospital and do something for him. The glands in the left groin were somewhat enlarged, although there was no question of syphilis in the case; and when he was admitted to hospital I removed them, in the hope that the moral effect of the operation would be beneficial. He was very restless after operation and displaced the dressings a good deal, but in spite of this the wound healed up in a fairly satisfactory way. Imme-diately after the operation the pains that he said he had suffered before operation dwindled into insignificance, and he commenced to describe the terrible pains he now suffered on account of the operation, blamed me for doing it, and talked about the healthy, painless state he was in before he was touched. We showed him the notes recording in his own words the "terrible symptoms" he said he suffered from before the operation as a proof that at the worst we had only failed to relieve him. It was no good, we had to refuse to see him any more, and the last time I heard about him he had settled down into his old condition and had gone to work. The less you have to do with such cases the better.

In regard to the five cases reported as being so say, in the first place, that the condition of the patients was beyond their control. The condition was not imaginary, but insanity, mania, intense neuralgia along distinct nerves and always there, not described with a placid, smiling face, but with the patient writhing in agony, not talking about agony, etc.

In the second place, the operations were undertaken for distinct diseases, and such as would be undertaken in a healthy person. The removal of the splints for the small abrasion on the heel was not undertaken to cure the insanity, but done in the ordinary course of surgery; the shortening of the round ligaments for an acute displacement was a thing to be done for its own sake, although it was undertaken in the hope that the mental state might be relieved thereby as well as to relieve the discomfort of the disease. The elevation of a depressed fracture of the skull was the proper treatment for the traumatism of the head, the removal of the large fatty tumour was the thing to do, irrespective of the neuralgia, and the hysterectomy for the diseased uterus, that had several times brought the patient to the brink of the grave through hæmorrhages was a sound operation, irrespective of the mental con-dition of the patient. The pathology and atiology of mental diseases is still obscure, and we cannot tell what influence lesions of the body may have on the My cases seem to me to show that if there is a distinct disease that ought to be treated in an ordinary sane individual, and if that disease occurs inter-currently with mental disturbance of unknown causation and of an acute character, then I say that distinct disease should be treated, and can be treated successfully, notwithstanding the mental condition, and with the hope that the mental symptoms may also be cured.

This advice is different to the usual practice where the operation is often postponed till the mental condition improves, but the cases I have given, and similar others that I could give, plead strongly for

my opinions.

The nursing arrangements in these cases must be very complete and effectual to prevent any mishap in the after treatment of such cases, and they should not be undertaken unless sufficient help and supervision are available.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by John O'Conor Donelan, L.R.C.P.I., L. R.C.S.I., Resident Medical Superintendent to the Richmond District Asylum, Dublin. Subject: " Alcoholic Insanity."

#### ORIGINAL PAPERS.

#### OATMEAL IN THE CURATIVE TREATMENT OF DIABETES MELLITUS. (a)

By PROFESSOR CARL VON NOORDEN, Director of the First Medical Clinic in Vienn

At the Congress of the German Scientists held in the year 1002 I gave for the first time a report about oatmeal cures in the case of diabetes mellitus. I had gained the experience that many diabetic patients had gamed the experience that many discrete parties had borne the diet of oatmeal very well, so that we could give them great quantities of the same, without causing glycosuria, while all other carbohydrates brought on excessive sugar secretions. Indeed it was possible sometimes under the influence of catmeal (50 grammes a day and more) to cause the sugar to dis-

<sup>(</sup>a) Abstract of Paper read in Professor Noorden's absence before the Indian Medical Congress, Bombay, Feb. 1909.

appear altogether, where the strictest diet, perfectly free from carbohydrates, did not render the unine perfectly free from sugar. It seemed even as if in such severe cases the oatmeal had a more favourable effect and was borne better than in slighter cases of diabetes. These experiences as to the effect of oatmeal were quite paradoxical, i.e., they seemed to contradict all former experiences as to the influence of carbohydrates on diabetes mellitus. One must remember that 250 grammes of oatmeal contain not less than 180 grammes to 190 grammes of pure starch.

In the 6½ years since my first publication a number of communications on the subject from other authors have appeared. Most of them endorsed my opinion entirely, others differed from them. I can perfectly well understand that some of these writers arrived at unfavourable results, for firstly it is absolutely necessary at the commencement of an oatmeal cure to keep strictly to definite rules, acquired by experience, and this was not always the case with those who had had bad results. And secondly I have myself pointed out from the beginning that only a small portion of diabetic patients are benefited by the oatmeal cure, while the majority are unfavourably influenced by it. He who has only to do with single cases will, for this reason, never be able to form a correct opinion.

Since I made a trial of the catmeal cure for the first time in the year 1899 I have treated 2,000 cases of diabetes for weeks in my public and private clinics. In the case of 400 of these patients the oatmeal cure was applied, and I am now in a position to give a definite judgment as to the practical value of the same, although we are still far from being able to offer an explanation of this enigmatical result.

#### METHOD OF PROCEDURE.

I will next explain my method of procedure in the oatmeal cure:—It is absolutely necessary before beginning the oatmeal cure to cleanse the urine entirely or almost entirely from sugar. This is done by restricting the patient for some days to the usual diabetes diet of absolutely no sugar and no starchy foods. If by this means they are still not free from sugar, as sometimes happens in severe cases, the patients must have two "vegetable days." The food consists on these days of the following elements:—

Tea, coffee (without additions), meat broth, made from beef, veal, mutton, or chicken, five whole eggs (hens' eggs) and five yolks of eggs, fresh vegetables as spinach, green salad, cucumbers, tomatoes, cauliflowers, asparagus, sauerkraut, etc., butter, bacon, marrow of bone—oil, lemon, vinegar, mineral waters, ½ bottle of claret, 1 or 2 small glasses of cognac or whisky.

One finds in the severest cases that small quantities of sugar remain in the urine. Sometimes the aceton-bodies increase.

The oat cure consists in the daily administration of 250 to 300 grammes of oatmeal, best given in the form of gruel or porridge, every 2 hours, 200 to 300 grs. of butter, and about 100 grs. of vegetable proteid or 8 eggs may be taken in addition. Most of the patients prefer the eggs. Nothing else is allowed except black coffee or tea, lemon juice, good old wine or a little brandy or whisky. In many cases you will see that these large quantities of oatmeal agree excellently with the patient and that either no sugar at all or only 20 to 30 grs. can be found in the urine, this shows that far the largest quantity of carbohydrates of the oatmeal have been assimilated.

After the 3 oatmeal-days it is absolutely necessary to let 2 vegetable-days follow; should the urine not have become sugar-free during the oatmeal-days, it will become so in pearly all cases.

will become so in nearly all cases.

It is exceedingly useful then to let again 3 oatmeal-days follow at once, upon which 2 vegetable days should succeed.

Now only may one begin to let slowly other foods be added to the foods which are allowed on the vegetable-days. One may best try with an addition of fish 200 to 300 grammes, and only when the proof has been given, that fish does not let sugar reappear in the urine, some meat may be taken. In severe cases,

however, this should never be more than 200 grammes weighed cooked. Later on, cheese and cream are allowed. Now the patient has again arrived at a diet, which is called the ordinary strict diabetic-diet. One will notice, that he now with this diet eliminates much less sugar, and that the quantities of aceton are much smaller than they were before the oatmeal cure began. It is then allowable to try small quantities of other carbohydrates (bread, potatoes, and others).

PRACTICAL RESULTS.

My practical experiences are the following:-Amongst about 400 patients upon whom I tried the oatmeal cure I gained excellent results with 28 per cent. that is such results as can be compared with the above example. The best results were gained with children, young men and women and grown-up people to about 40 years old. For older diabetics the oatmeal cure is not so suitable, although I had some good results with people between 50 and 70 years of age. For the best results were obtained in medium cases. Very severe and quite slight ones are not suitable for this cure. Diabetic patients with nephritis should on no account be exposed to the catmeal treatment, because mostly ædema results which only disappears slowly. Often the oatmeal produces strong diarrhoea. This can be prevented by ordering tincture of opium during the cure, which will make the diarrhoza disappear at once (5 times a day 5 drops of tincture of opium). Such patients who suffer from bad secretion of the pencreatic gland may not undergo the oatmeal treatment. They would acquire severe fatty diarrhœa (steatorrhœa), which leaves them weakened.

The good results of the cure will always fail to come, as soon as other carbohydrates are added to the oatmeal, and it is also disadvantageous to add meat, or extract of meat, or meat broth, or casein, plasmon and other foods of this kind. Should diabetic coma threaten there cannot be found a better means to avert the danger of the auto-intoxication than the catmeal cure. In such cases it is most important to cause the re-sorption and assimilation of as many carbohydrates as possible. Next to this of course alkalines must be supplied.

The oatmeal treatment cannot cure the diabetes mellitus, but it can considerably diminish its danger. It is of the greatest importance that from time to time the patients should assimilate large quantities of carbohydrates. Thereby the danger of acid poisoning is averted. For this reason I prescribe, in such cases, in which the treatment has turned out well, a repetition of the oatmeal cure 4 or 5 times a year. The cure always takes one week as follows, that is, 2 vegetable days, 3 oatmeal days.

One often has technical difficulties in accomplishing the cure, and it is nearly always impossible to achieve good results if the patient undergoes the cure the first time in his own home. I therefore always insist upon his undergoing the treatment for the first time in a hospital or in a sanatorium. As soon as once he has learned how to behave during the oatmeal-days, the later cures can easily be undergone at home.

EXPLANATION OF THE RESULT.

It has been said, that the results of the oatmeal cure depend upon the diminution of the proteids; one knows, that diabetics often stand more carbohydrates when taking only few proteids, than they do when taking many proteids. But this interpretation is wrong. The results of the cure are the same, if roo gr. of vegetable proteids or 8 eggs are added—even more eggs could be allowed, but meat would disagree. It has been said that glycosuria does not result from oatmeal, because the starch of the oatmeal ferments in the intestinal canal and that consequently only fatty acids and no carbohydates are resorbed. But this objection is wrong; for the composition of the fæces is in far the most cases quite normal; moreover the decrease of aceton proves with certainty the resorption and assimilation of carbohydrates.

I previously thought and taught that the particular nature of the amylum, which oatmeal contains, was the reason of its good assimilation. It is known that some carbohydrates agree better with diabetic persons

than others, such as lactose, which is better tolerated than ordinary sugar and all the other ordinary amyloses. We have tried to prepare the starch of the oatmeal quite pure and to compare its effect upon the diabetic patient with the starches of various other substances (from wheat, rye, potatoes, etc). But the pure starch of oats acts just as unfavourably upon the glycosuria as other starch does. However, it is sure that the starch, when prepared pure, undergoes certain alterations in its chemical constitution. Possible it is that the starch of oats in its original constitution possesses quite different qualities than the pure oat starch, and that, indeed, it agrees better with the diabetic than other starches. Latterly our attention is directed to the fats of the oat. We found that the alcoholic and etheric extract of the oat contains substances of very great and toxic power. If you give to a small dog a subcutaneous injection of 1 gramme of concentrated oat-extract, which contains the fats and the lipoids, the animal dies paralysed in 24 hours.

#### EXPERIMENTS ON ANIMALS.

We caused artificial glycosuria in dogs by injection of adrenalin. When, at the same time, we injected a small quantity of oat-extract, no glycosuria arose. As there is no doubt that the adrenalin diminishes the internal secretion of the pancreatic gland, the probability arises that the oat-extract has the opposite effect, *i.e.*, that the extract is a stimulus for the pancreatic secretion. After extirpation of the pancreatic gland in animals, the oatmeal treatment has a very bad effect, and also the oat-extract does not diminish the glycosuria. Also this seems to prove that the oat-extract only acts by influencing the internal pancreatic

secretion in a direct and specific manner.
You must acknowledge that these experiments give a good prospect for the treatment of diabetes in men. a good prospect for the treatment of diabetes in men.
Until now we did not dare to administer the oatextract in cases of diabetes, because all the extracts which we prepared were eminently poisonous;
but, of course, the experiments are continued. We
hope to gain such extracts of oats, which are not so
poisonous, but which produce the wished-for good
effect upon glycosuria.

As we see things to-day, we presume that the astonishing effect of the oatmeal treatment is due to the circumstance, that with the oats we introduce into the body small amounts of a substance which acts as a stimulant upon the internal secretion of the pancreatic gland. Why this good effect only is met with in certain cases and missed in others we cannot yet tell.

#### THE TREATMENT OF GONORRHŒA IN GENERAL PRACTICE.

By J. EDWARD McCRACKEN, L.R.C.S.I., Honorary Surgeon to the Liverpool Hospital for Cancer and Skin Disease.

THE internal remedies for the amelioration of the discomforts attending an attack of gonorrhea have always appeared to me to be amongst the most clumsy and unpalatable possessed by our limited Pharma-copeia. Copaiba, cubebs and sandal-wood oil practically exhaust the remedies at our disposal, and every practitioner is fully aware of the trouble there is in the administration of these.

In my own practice I have a number of patients whose youthful indiscretions at times lead them astray, and the great difficulty with such people is to astray, and the great difficulty with such people is to give them medicine which they can take regularly without their employers' suspicions being aroused, for cases have not infrequently come to my knowledge where this has led to a notice of discharge being given. This may be a point which need not concern the practitioner, but it has many a time aroused my purely human sympathies.

I have for long kent an over eve in the book that

I have for long kept an open eye in the hope that some enterprising chemist would have solved the problem of rendering these remedies free from nauseous and irritating by-effects, but until some few months ago was quite unaware that any reliable, palatable and portable internal form of medication existed. There may, of course, be more than one on the pharmaceutical market, but I have only, more or less accidentally, stumbled across one, and my success with it has been so pronounced that I venture to

cess with it has been so pronounced that I venture to write about its effect, along with some other points, which will, perhaps, be of interest to busy practitioners who, like myself, cannot keep pace with scientific progress as they would like.

The substance to which I allude has the trade-name of Allosan, and is stated to be the allophanic acid ester of santalol; that is to say, it is a solid, organic preparation of the active principle of sandal-wood oil, with no taste whatever, and no irritating action on with no taste whatever, and no irritating action on the mouth, intestines, stomach, kidneys or bladder.

It is not one of those keratin-coated pills which are often so disappointing owing to want of solution. I hold no brief whatever for it, and merely wish to place on record some valuable experiences which I have had with it in the hope that others may be stimulated to test it. I have for a considerable time relegated copaiba to oblivion, because of its irritating, nauseating effects, and, until I discovered allosan, had distinctly felt its loss, having to rely upon various proprietary blends of cubebs and sandal oil. But since my discovery, if I may so term it, I have discarded these altogether. For some time I felt that I had a friend in urotropine, but one or two cases of hæmaturia, clearly due to it, compelled me to be very It is not one of those keratin-coated pills which are hæmaturia, clearly due to it, compelled me to be very discerning in its employment, where there was genitourinary mischief of at all an acute character.

I am a distinct advocate of the combined internal and external treatment of gonorrhœal conditions, and always employ them together from the beginning to the end of the case. I feel fairly confident that the internal medication not only assists the local cure, but also prevents general gonococcal infection, and particularly arthritic troubles. Salol was at one time one of my stock adjuvant remedies, but it cannot be pushed very far because of the gastro-intestinal derangement, and carboluria, not infrequently induced.

Sandal-wood oil is probably the best specific for internal use, but I have had quite a considerable number of cases of lumbar pain develop during its administra-tion, and practically every single patient treated by it complains of nausea and dyspepsia in a very short time. None of the untoward symptoms have appeared under the administration of the organic derivative mentioned. The sedative and anti-catarrhal actions of this compound are noteworthy, as is evidenced by the rapid relief of painful urination, the almost entire absence of distressing night erections, and the marked progressive lessening of urethral discharge.

Moderate purgation I hold to be almost a necessity,

especially in the acute stages of gonorrhæa, and gives wonderful relief in posterior urethritis. A favourite remedy of mine is mag. sulph. 3 dr., combined with pot. bromid. 20 to 30 gr., as a nightly potion.

The abortive treatment is a common-sense one and deserves more extended trial. It has not been practically successful in my hands, and one would like to know whether the failures are as eagerly recorded as

the successes in the medical journals.

For gleet I think nothing can improve upon silver nitrate ointment (3 or 4 gr. to the ounce) passed on a sound, and retained for three or four minutes at first, the time of retention being gradually increased. Coupled with gentle massage over the sound (a method I have seen recommended some years ago in the medical press), I think it has two great advantages. It ensures a pretty thorough application of the remedy to all the crevices of the dilated urethra, and enables it to reach the posterior urethra, whilst the use of the sound must naturally check the contraction of an incipient stricture, and may possibly cure it altogether—a thing one cannot hope from the use of soft

In the female I find the treatment advocated by Routh sound, practical and most effective. After a preliminary douche the vagina should be thoroughly swabbed up to and including the cervical canal, using a Fergusson speculum. The antiseptic should be a Fergusson speculum. The antiseptic should be fairly concentrated, and I usually employ mercuric chloride, or biniodide, or lysol. After the vagina has been swabbed the external genitalia must be thoroughly cleansed with a similar solution. The treatment of the urethra on these lines is rather pain-

ful, and one has usually to rely upon bougies. Naturally, one cannot employ this method until the acute stage has passed off, but it should never be undirected of the deleved of the deleved. duly delayed, as its primary object, of course, is to prevent the onset of specific salpingitis. In a few instances the antiseptics mentioned have not brought about success, but in all a 5 to 10 per cent. solution of silver nitrate or protargol have promptly cured after two or three applications at most. An excellent two or three applications at most. An excellent vaginal suppository for use in patients who object to the above treatment is one composed of plumbines. acetat. 5 gr., and opium 11 gr., in the acute stages, followed by a suppository of the following later on: Acid. carbol. I gr. and iodoform 3 gr.; if there be a tendency to chronicity in the discharge, add alum 10 gr. to the latter.

In regard to silver preparations, one may say that they are all open to the objection that they stain linen rather badly. The inorganic salt (nitrate) is always also open to the serious drawback that by contact with the tissues, etc., insoluble chlorides or albuminates are readily formed, and an impermeable coating produced, which naturally interferes with the penetration of the reagent.

New silver compounds are being produced in such numbers that their manufacturers must be throwing a severe strain on the Mexican mines. Most of these a severe strain on the Mexican mines. Most of these are, naturally, very expensive, and unsuited for general practice. Protargol, however, may be used in quite dilute solutions—even down to \$\frac{1}{2}\$ per cent., so that its use in practice becomes comparatively inexpensive. Many of these compounds are unstable, particularly the combinations with the organic acids, whilst I do not know of one which will keep for more than a few days in solution.

days in solution.

Of all the silver preparations on the market at or an the silver preparations on the market at present I have had no better results than with protargol. I think I may say that I have tried all the others at present known with exemplary patience, but without sufficient success, to justify me in adopting them in preference to the old-text-book remedies. Some practitioners have complained to me about the difficulty of making a solution of protargol, but I am bound to say I have never experienced any trouble at

My plan is simply to dust the substance so as to form a layer on cold water contained in a beaker or a large measuring glass, cover it over and leave it for a time. Agitation only renders the process longer and ultimate solution more imperfect. Transfer the solution to a dark glass bottle and the thing is done.

I have never, before the use of protargol, been favoured with such certain, rapid and permanent results as since I employed it. In a solution of from to I per cent. (I generally use the stronger solution) injected into a urethra previously washed out with boiled and cooled water, it will effect a cure more quickly than any other substance I know. It is, without doubt, not an easy matter for a patient, at any rate at first, to retain the injection for the half hour which is recommended, but after a while this becomes quite an easy matter. For chronic urethritis the full strength of the injection should be much greater, and it may be increased pretty rapidly up to 10 per cent. Coupled with the internal administration of allosan, one has, in my experience at least, an ideal programme of treatment for this all too common con-

As a test whether cure has been obtained in doubtful cases, I rely upon the simple method of providing my patient with a couple of glass slides which have been washed in carbolic and absolute alcohol, and wrapped in carbolised butter paper. He is instructed to express the urethra as completely as possible first thing in the morning on to one slide, cover it over with the other slide, rewrap in the paper and bring to me for microscopic examination. In cases of chronic urethritis, if gonococci are still present, there can be no question about the line of treatment—it must revert to the same procedure as if the inflammation were still acute, i.e., it must aim at the destruction of the causal cocci.

A few cases illustrative of the results of treatment

may be of interest:—

CASE I.—Male, 32, shop assistant, and compelled

to stand during most of the day at work. Painful urination and discharge four days after intercourse. Came to me late at night, and I merely put him on alkaline drugs and told him to come for more active. treatment next evening. On this occasion I gave him an injection of hydrogen peroxide (1 in 100) and showed him how to perform the injection himself. I also put him on allosan 15 gr., thrice daily, and gave him the usual cautions about diet. This treatment was persevered with for 14 days, at the end of which time not a sign or symptom of the disease remained.

Case 2.—Male, 24, clerk, and I suspect of dissi-pated habits; addicted to bouts of beer drinking. Disease developed five days after coitus. This patient came to me at once and confessed to having had two attacks before. I treated him on the same lines as the last case, but after a week he still complained of pain on micturition, which he said was getting worse. pain on micturition, which he said was getting worse. I discovered that he had recently been feeling so much better that he had "fallen from grace" and taken several glasses of beer. The urine was of high specific gravity and markedly acid. I put him on pot. citrat. 15 gr. t.d.s., for a couple of days, stopping the allosan during that time, but continuing the injections. At the and of the third week he was entirely cured and the end of the third week he was entirely cured, and was so astonished that he asked me for the prescrip-tion of the lotion and medicine, so that if ever he should need them again he would have them by him.

Case 3.—A rather severe case in an unmarried man, æt. 42. The discharge appeared three days after man, ex. 42. The discharge appeared three days after coitus, and was of a creamy consistency and full of gonococci. He was put on allosan with weak protargol injections, and told to drink freely of water and other innocuous liquids. There was a complete cessation of the gonorrheal discharge at the end of the ninth day of treatment, and next day there was nothing but proceed a little chorded denothing but prostatic mucus. A little chordee developed about this time, but was cured by inunction of the glans and prepuce with ung. sedativum. I thought him quite cured, but four days later he returned to me complaining of severe pain in the left testicle. On examination, the epididymis was found to be swollen and extremely sensitive. For this he was advised to use hot carbolic fomentations, I in 60, and the protargol injections and allosan were commenced afresh. At the end of three days more there was complete cure.

CASE 4.—Female, 25. Fille de joie. Date of onset somewhat uncertain—probably quite a fortnight ago. Profuse discharge and cystitis. Had been treating herself with lysol injections and capsules of copaiba for eight or nine days. Declined to submit to vaginal swabbing, so put her on allosan 12 gr., thrice daily, and gave the suppositories previously alluded to in this article. After three days' treatment the discharge had lessened considerally, and there was much less tenderness over the bladder. The treatment was persevered with, and at the end of another five days there was practically no sign of cretitie but the varied discharge that the property discharge the statement was persevered with and at the end of another five days there was practically no sign of cystitis, but the vaginal discharge still continued. The patient then consented to the vaginal swabbing, previously mentioned, protargol 5 per cent. being used. Next day the condition was infinitely improved, and after a second swabbing with 71 per cent. protargol, completely cured. Allosan was continued for three or four days longer, but this was probably unnecessary.

Though I have in one of the cases mentioned (No. 3) referred to a simple remedy for gonorrheal epididymitis, this is by no means the remedy I am attached to, which is naftalan. This is a substance which I have found of really priceless value in eczema in almost all its protean forms, but which I have only had occasion to use in some half-dozen cases of epididymitis, when I have employed it particularly in the acute stages. My practice has been to spread this substance fairly thickly on lint or linen and cover the entire scrotum with this; the usual suspender is, of course, always worn, and it is advisable to line this with cotton wool. A sitz bath, or the best substitute for it that can be improvised, is advisable night and morning, and if a couple of days' rest in bed can be secured so much the better. By means of naftalan, I have considerably shortened the duration of this painful illness, lessened the suffering, and had no relapses

whatever. None of my patients treated in this way required any opiate to tempt sleep. I am distinctly impressed with its value for this condition, and I propose to extend a trial of it to painful arthritic affections, and particularly those accompanying gonorrhœa, as it appears to have not merely an astringent and soothing effect, but to be absorbed, and thereafter exercised an antiseptic effect also. This last opinion is based on the remarkable curative effects it has on parasitic skin diseases.

# TIODINE IN THE TREATMENT OF DISSEMINATED SCLEROSIS.

By WILLIAM MURRELL, M.D., F.R.C.P.,
Physician to the Westminster Hospital, and Lecturer on Medicine and
Clinical Medicine.

Thiosinamin, or allyl-sulpho-carbamide, is prepared by warming oil of mustard with alcoholic solution of ammonia.

Fibrolysin is said to be a salicylate of thioscya-

min.

Tiodine is thiosinamin-ethyl-iodide.

All these substances have been used for the absorption of fibrous tissue, and have been employed in Dupuytren's contraction, for the removal of scar-tissue, in pyloric obstruction following gastric ulcer, and in various diseases of the ear and eye.

For some time past I have used tiodine in various chronic scleroses of the cord. It is slow in its action, and it is hopeless to obtain any very striking results unless the patient is willing to submit to a course of treatment of from four to six months' duration; and an even longer period may be required. This in a general hospital presents some difficulty, especially when the average stay of each patient is only twenty-six days and the bed costs nearly £2 a week. Moreover, patients are anxious to resume work as soon as possible, and take their discharge when there is a definite improvement in their condition. They cannot be treated as outpatients, for care has to be employed in the administration of the injections, and people in employment cannot attend once, much less twice, a day. I have many incomplete cases, but they are useless for publication.

Tiodine can be obtained in glass phials, each containing 0.20 centigrammes in 1 cc. I never give it by mouth, but always hypodermically, and with

strict antiseptic precautions.

On January 29th, 1908, I published in The Medical Press and Circular the case of a man, aet. 30, suffering from that form of lateral sclerosis known as "Erb No. II.," who was treated with tiodine. He was under observation, with intermissions, from April 8th to October 25th. He had twenty-six injections—an insufficient number, but the result was satisfactory. The first injection was followed by a well-marked reaction, with high temperature, which lasted for five days and terminated by lysis. It may have been an acute lobar pneumonia, but there were none of the ordinary signs or symptoms of that disease. I have since used it in a considerable number of cases of various kinds, but in none of them has a similar condition been observed.

The case I now record is one of disseminated sclerosis, and the patient has been in hospital for five months, during which time she has had 168 injections. The improvement has been exceptionally favourable, and I think it better to publish it rather than to wait for the chance of obtaining a series of cases involving probably a long delay.

R. M., æt. 22, a heavily-built, stolid-looking woman of Russian parentage and Jewish origin,

was admitted on November 3rd, 1908, suffering from disseminated sclerosis. She stated that from the age of thirteen she had been more or less shaky, but during the last six months had been so much worse that she was unable to follow her occupation as a servant. There was no family history of nervous disease and none of tubercle or cancer. Her previous illnesses comprised scarlet fever and whooping-cough, but there was no indication of syphilis, either congenital or acquired.

On admission tremor was very marked, but confined to the muscles in actual use. She was unable to thread a needle or to sew and experienced much difficulty in feeding herself. Her gait was spastic, the legs being stiff and moving only from the hips, whilst the knees were slightly flexed. She could not walk without assistance and could not stand alone. The tendon reflexes were all greatly exaggerated. Nystagmus was a prominent feature, being most pronounced on lateral deviation, but also present on looking upwards and downwards. The speech was staccato, halting and scanning in character. These were all the symptoms, except that the patient complained of pains in the limbs.

On November 7th she was put on tiodine, which was administered once daily until February 9th, after which the injections were given twice a day with occasional omissions. Up to March 11th, when the treatment was temporarily discontinued, the patient had had 134 injections, most of them in the buttock or abdominal wall, but a few in the arms. There was no reaction, the highest temperature recorded during her stay in the hospital being 101°, and that only once. Each injection produced a hard subcutaneous nodule somewhat smaller than a pea, but they did not suppurate. On March 4th, two fluctuating swellings appeared on the site of the two most recent injections, one the size of a walnut on the thigh and one on the arm as large as a hen's egg. There was no elevation of temperature and no local redness or inflammation, although there was a sense of tension with pain. The tumours consisted of blood-stained fluid with red blood corpuscles and leucocytes, mostly polymorphs.

The progress of the patient was one of uninterrupted recovery almost from the first. On February 25th she could stand unaided, walk steadily, and carry cups of tea to the other patients. She no longer complained of pains in the limbs. On March 2nd there was no tremor in the left arm and that in the right arm was very slight. She could thread a needle and sew perfectly well. The nystagmus had so much improved that she could read without inconvenience. The staccato character of the speech had completely disappeared. On March 26th, as a matter of precaution, the injections were resumed, but there was no further local trouble. She was discharged on April 3rd, and although she still occasionally comes to the hospital, there has been no return of any of the

symptoms.

## DILATATION OF STOMACH. (a) BY HARRY CAMPBELL, M.D., F.R.C.P.

The essential condition here is atony of the stomach walls, the muscular fibres of which tend to be flaccid and fail to contract properly upon the swallowed food; in other words, the "gripping" power of the stomach is at fault, the consequence being that food is unduly retained in its interior, and, just as in the case of the bladder with enlarged prostate, there is "residual" urine, so in the case of the stomach there is "residual" food, which tends

(c) Abstract of a Lecture.

to putrefy and cause irritation of its walls, and thus further aggravate the condition.

If there be definite obstruction, such as that arising from the cicatricial contraction of a pyloric ulcer, or the presence of a "ring" carcinoma, the

indication is gastro-enterostomy.

If there be no definite obstruction, the causes are such things as set up a catarrh, in the forefront of which I would place alcohol taken on an empty stomach, and, to a less extent, the taking of large quantities of tea and coffee. The condition is also sometimes found amongst those who habitually over-distend their stomachs by the ingestion of too large quantities of food—in plain words, gorging.

In the treatment of these non-obstructive cases the indications are:—Not to impose too much work on the stomach for a given time—i.e., the meals to be small in quantity and to be taken at more frequent intervals. The meal to be "dry," and meat should be the staple article of diet. Another indication of importance is the avoidance of carbo-

hydrates.

If the case be a severe one, the stomach to be washed out just before retiring to sleep-five clear hours after the last meal. This will remove any "residual" food and allow the stomach plenty of time for rest.

A tumberful of hot water to be sipped the first thing in the morning, so as to flush the stomach of any adherent mucus which may have collected

In aggravated cases, gentle massage applied one hour after a meal is often beneficial, as by such means the stomach walls are stimulated to contract.

N.B.—The condition is not to be mistaken for "achlorhydria," from which it can readily be differentiated by the results of a "test meal."

#### **OUT-PATIENT'S ROOM.**

METROPOLITAN HOSPITAL. Incontinence of Urine.

By LEONARD WILLIAMS, M.D., M.R.C.P.,

Assistant Physician to the Hospital, Physician to the French Hospital.

This patient, who is æt. 69, has been attending here for five weeks. He is an ancient master mariner who, you will observe, is smart and dapper in appearance and certainly does not look his age. He came to us complaining of diurnal incontinence of urine of ten years' duration. The accidents used to occur infrequently at first, but they have gradually increased in frequency, and when he first presented himself to us he used to wet himself as often as four times a day. He gives a history of two or three attacks of gon-orrhœa, but, as far as he is aware, he had never had syphilis. The nature of the sphincter trouble is not such as to suggest organic disease; that is, there is no difficulty in starting the act of voluntary micturition, and his enuresis is diurnal only; it is never nocturnal. On examination his urine was found to be perfectly normal. The bladder was not full, and digital exploration per rectum, which was very carefully performed by Mr. Sydney Vosper, failed to reveal the presence of an enlarged prostate or any other local cause for his trouble. A general physical examination of chest, abdomen and nervous system elicited nothing of any importance, and certainly nothing which seemed to throw any light whatever upon the origin of the incontinence. Functional troubles of this kind are not altogether unusual in men past 65 years of age. They are, however, commonly attributable to enlargement of the prostate and often entail what is called a "catheter life" upon their unfortunate subjects. I have advocated the treatment of slight degrees of this condition (a) by drop doses of the tincture of cantharides, three times daily, a method on which I have learned to place considerable reliance, and had it not been that our minds, that is, Mr. Sydney Vosper's and my own, were full of another method, I should have treated this patient by means of this drug with very considerable confidence. Our experiences had, however, engendered in our minds so much enthusiasm for the effects of thyroid extract in the management of nocturnal enuresis in children, that we determined to see what effect it would produce in the case of this elderly gentleman. The story of our experiences with this drug, how and why we thought of it, and the miracles which it wrought for us, are told in the Lancet of Saturday, May 1st, 1909, and need not be repeated now. Suffice it to say that out of 26 cases of persistent enuresis in children, treated by thyroid extract, we have had but one failure, and that some of the cases are so dramatic in their success as to be almost incredible. I had the pleasure of showing a good many of them at the Polyclinic on the 27th April.

But to return to our present patient. He presented himself on March 17th, and, moved by our above-mentioned results, we determined to treat him with 5 grains of thyroid extract, three times daily. On March 23rd the patient reported himself much improved. The incontinence was decidedly less. On March 30th he reported that, whereas formerly, his infirmity overcame him three or four times a day, during the past week he had been troubled on three occasions only. On April 6th there had been no incontinence. On the 13th no incontinence.

The moral is therefore obvious. Thyroid extract not only controls the vast majority of cases of nocturnal enuresis in children, but it also effectually counteracts the functional incontinence which is liable to occur at the other extreme of life, bringing grey hairs with physical and mental suffering, to an unregretted end.

#### **OPERATING THEATRES.**

GREAT NORTHERN HOSPITAL.

STRANGULATED RICHTER'S HERNIA.-MR. PEYTON BEALE operated on a man, æt. about 40, who had been admitted with the following history: On the evening of the fifth day before admission he had been eating mackerel. On the same night he was seized with violent colicky pains in the abdomen, which persisted to the time of admission. There had also been vomiting fairly persistent, and for the last two days this had been definitely fæcal. Temperature had not been raised, and the pulse had been and was abnormally slow. The abdomen was perfectly soft, quite easily palpated, not tender, and not in the least distended. The patient looked very ill. His published. distended. The patient looked very ill. His pupils did not contract to light, but he expressed himself as feeling well except for the occurrence of occasional colicky pains, vomiting, and inability to take food. Having been prepared, the abdomen was opened in the middle line below the umbilicus. On drawing aside a very distended coil of small intestine, a knuckle of bowel was seen projecting into a circular aperture about half-an-inch in diameter. The aperture was seen to be in the parietal peritoneum, and, on feeling it, it became evident that it was the internal abdominal ring. The parietal peritoneum and fascia transversalis were both very lax, so much so that the imprisoned knuckle of intestine, when gently pulled, could be brought outside the abdominal wound, thereby drawing forward the fascia transversalis with the internal ring and the parietal peritoneum covering With a little gentle manipulation the knuckle of imprisoned small intestine was easily pulled out of the ring, when it became clear that about three-quarters only of the lumen of the gut had been strangulated. After reduction it soon resumed its normal colour, and peristalsis became evident, the contents of the distended portion of intestine gradually making their way into the portion beyond the strangu-

lation. The sac of the hernia was merely a little peritoneal pouch pushed into the internal ring. As the strangulated portion of intestine was reduced, care was taken that none of the fluid (only one or two drops) within the sac was allowed to escape into the peritoneal cavity. The abdomen was quickly and thoroughly irrigated with hot salt solution, and the wound closed with the exception of a small aperture

in which a gauze drain was placed.

Mr. Beale remarked that the first point of interest was the fact that, although both groins and the whole of the abdomen were carefully examined, no trace of a hernia could be found. He drew attention to a case of femoral hernia which was reported in "Operating Theatres" of February 3rd, 1900, in which there was no trace of any hernia, although the whole of the abdomen and all the hernia apertures had been very carefully examined. The second point of interest was the fact that fæcal vomiting had been present for at least two days, and the intestinal obstruction had not been complete, nor was there the slightest abdominal distension. He said this was not infrequently the case in a Richter's hernia, and it proved that sufficient inverted peristalsis of the small intestine to produce by the firm constriction of only a portion of the lumen of the small intestine. The third point was the man's aspect and his dilated pupils, showing that he was suffering from a very acute septic intoxication. In cases where there was complete or partial obstruction to the onward flow of the contents of the small intestine, toxines, probably a bacillus coli, and other poisonous substances were absorbed by the blood and lymph. This produced the dilatation of the pupil, and appeared also to affect the brain so as to produce a diminution of the sense of pain. This was, of course, very commonly seen in the last stage of general septic peritonitis, where the pupils were commonly found widely dilated, and the patient quite free from pain and tenderness on palpating the abdomen. The fourth point of interest was the exceedingly lax condition of the fascia transversalis and parietal peritoneum; he did not remember having previously seen any case exhibiting this before. Here it was quite clear after reduction of the hernia that the internal ring with the parietal peritoneum covering it could be easily brought up from the iliac region to the incision in the middle of the abdominal wall. It was not unasual to see a very lax parietal peritoneum, but he had not seen a loose and lax fascia transversalis.

Malignant Tumour of Descending Colon.—The

same surgeon operated on a woman, æt. about 30, who had been admitted with an abdominal tumour in the left side. The tumour was ovoid in shape, about seven inches long and five in diameter, freely movable, quite painless. The patient did not know of its presence until she attended the out-patient department. history was as follows: -For the last five months she had complained of irregularity of menstruation and pain in the left side of the abdomen at the periods; she had never complained of any trouble as regards her bowels, and she had never passed any blood. Such was the absence of symptoms that it was quite doubtful whether the tumour should be investigated or not. In the out-patient department it was thought to be a renal tumour, and indeed it appeared exceedingly like a large hydronephrosis of the left kidney; the patient had no symptoms of urinary trouble, and an X-ray photograph of the tumour showed nothing; so that it was really upon the likelihood of its being a renal tumour that operation was performed. It may be stated that rectal and vaginal examination revealed nothing, and the only other likely diagnosis seemed to be an ovarian dermoid. Upon opening the abdomen it was at once evident that the tumour was a large malignant mass, involving the splenic flexure and descending colon, and clearly starting from the mesenteric attachment. After ligaturing the mesentery and adhesions in about 30 places, the colon was clamped about two inches above, and the same distance below the tumour; the whole was then brought outside the abdomen and excised; the two ends of the colon were stitched to the upper and lower ends of the wound respectively, and the clamps left on until it should be seen which was the upper and which the lower end of

the colon. It was hoped that this would be evident in two or three days, when the clamps would be removed, and in about a fortnight's time the ends of the colon would be sutured together. After removal the tumour was opened up, and appeared like a very hard colloid carcinoma. The whole of the mucous memcolloid carcinoma. The whole of the mucous membrane of the bowel within the tumour had disappeared, and from its appearance it seemed very remarkable that the patient should not have had any symptoms of obstruction or hæmorrhage from the bowels.

#### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD FRIDAY, APRIL 23RD, 1909.

Mr. R. CLEMENT LUCAS, F.R.C.S., in the Chair.

MR. HUGH LETT showed (1) cystic hygromata, in a girl, aged 15 months, under the right arm, on the right elbow, and over the right scapula. The mass in the axilla was soft, with irregular nodular areas. The skin attached to it was attached and dimpled. There were no dilated veins or pulsation. (2) Multiple masses under the skin of the thigh. The patient was a girl, aged 6 months. The swellings had been noticed since birth. On seeing the case three weeks ago the appearances had suggested lipomata, but one of the masses had now become softened and discoloured, and showed ulceration. The condition was, therefore, one snowed ulceration. The condition was, therefore, one of multiple tuberculous abscesses (3) A tumour of the femur in a boy, æt. 15. He had noticed a lump in the right thigh four years ago, which had been growing slowly since. It causes the patient a little pain when the weather is damp. The urine contains a trace of albumin. (4) A case of multiple osteomata in a boy, æt. 4½. He appeared to be normal until the age of 18 months, when his mother noticed lumps on his Osteomata can be seen or felt at the ends of both tibiæ and humeri, at the adductor tubercles of the femora, on the vertebral borders and spines of the scapulæ, at the outer end of the right clavicle, on the ribs at the junctions of the cartilages and bone, and symmetrical nodes on the skull. The boy was well, except that he got tired very quickly. The tumours were roughly symmetrical.

The CHAIRMAN said he had but little doubt that the three small swellings in Case 2 were tuberculous skin The fact that one had become discoloured abscesses. The fact that one had become discoloured since Mr. Lett saw it three weeks ago indicated the probable contents of the others-namely, sweet white pus. With regard to the tumour on the thigh, he thought that it was an ossifying enchondroma, usually known as an exostosis. The photograph showed that the bony part was growing, and as it was single he

would be inclined to remove it.

Mr. R. WARREN showed a specimen from a case of congenital stenosis of the rectum, colon, and part of the ileum. The baby was three days old, and had passed no motion since birth. The finger could be passed 1 to 2 inches into the rectum, and a small tube of 5 mm. bore would pass 3 inches or more. A little was performed, but the child died. Post-mortem, the gut was stenosed, but not blocked. Water could be passed both ways with a syringe.

Dr. PARKES WEBER showed a case of ductus

arteriosus without murmur. The child came under observation, aged 2 weeks, suffering from debility and cyanosis of variable degree. It could not take the breast properly. There was no murmur, and no certain signs of valvular disease could be detected. Its temperature was sub-normal, and it was subject to respiratory spasms, during which cyanosis was increased. There were 41 million red corpuscles to the cubic millimetre of blood. The child died at 6½ weeks. The foramen ovale was not completely closed, admitting the passage of a pencil 5 mm. in diameter. The ductus measured 15 mm. in length, and its channel was about 5 mm. in diameter, being a little wider at its aortic end; the aorta was very slightly constricted where joined by the ductus. The lungs showed atelectatic patches in the upper lobes. The liver was slightly enlarged.

Dr. CAUTLEY asked Dr. Weber whether he ascribed the cyanosis to the patent ductus or to the condition of the lungs. He thought himself that it was not due to patent ductus, because, if there were mixing of the bloods, there would be an excessive number of red cells, which was not the case.

Dr. WEBER thought that the atelectatic patches had a share in producing the clinical condition.

Dr. A. J. JEX-BLAKE showed a case of EXTREME DEFORMITY OF THE CHEST, WITH FIBROSIS OF THE LEFT LUNG.

The patient had always been weakly. There was a history of consumption on the father's side of the family. At the age of 7 the patient had bronchitis and pneumonia, and three months later was admitted to hospital with an abscess over the left lower rib which was found to communicate with the pleura. Two operations were done to let out pus. Three months later the whole left chest was flattened and dull, with tubular breath sounds. The fingers showed clubbing. There was a copious discharge from the tube and from a sinus close to the sternum. operations had been done subsequently. He had had a chronic discharge on and off from one or other of the sinuses in the chest ever since. The patient showed extreme deformity and collapse of the left chest, causing scoliosis and much limitation of the move-ments of the spine. The heart was displaced, the right lung emphysematous, and the fingers cyanosed and clubbed. Dr. Jex-Blake asked whether it was now too late to institute expansion of the lung, as there had been none for 41 years? Were breathing exercises or an operation such as decapsulation of the lung

or an operation such as accupational likely to do good?

Dr. E. I. Spriggs asked whether the child was bringing up sputum? If there was evidence of considerable dilatation of the tubes, he doubted whether respiratory exercises would be of much value. If not, he thought that, although they would not cure the deformity, they would prevent it becoming still more accentuated as the child grew older.

The CHAIRMAN thought that anything which might

bring about amelioration should be tried.

Mr. R. WARREN said he had seen a similar case, though less severe, improved by deep breathing, with chest had expanded one or two inches, and the scoliosis was improved. He thought it worth trying in the present case.

Dr. G. PERNET pointed out that there were some slight scars at the angle of the mouth, and a very little depression at the bridge of the nose. French writers considered that fibrosis of the lung was more liable to occur in patients who were syphilitic. He would like to hear the opinion of the physicians present on that point.

Dr. JEX-BLAKE replied that the child suffered from bronchitis on admission, but at the present time was not bringing up any sputum. There was no family history of syphilis. The mother had eight living children, a ninth had died in infancy, but there were no miscarriages.

Dr. G. CARPENTER showed a case of

CONGENITAL DILATATION OF THE COLON.

The child was a female, aged 1 month. Diarrhœa and vomiting began in the first week, and ceased on and voluming began in the first week, and ceased on March 28th. The bowels were then not opened until admitted to hospital on April 2nd. The abdomen was then enormously distended. Per rectum, thickening of the bowel could be felt, and offensive fluid fæces of fairly normal colour followed the withdrawal of the finger. Three days later, after treatment with enemas and aperients, normal motions were passed, and the distension had disappeared. It then began to increase again, but was relieved by turpentine and enemas. An X-ray photograph was shown, in which the colon, which had been injected with a solution of starch and bismuth, was obviously dilated, forming a U-shaped tube, with the base of the U at the splenic flexure, the ascending and transverse colon forming one leg of the U, and the remainder the other. He invited the surgeons to pass an opinion as to whether operation was advisable.

Dr. E. I. Spriggs thought that if the diagnosis was to rest on the skiagram shown, it was on an insecure basis, especially when it was remembered that a solution of starch and bismuth had been injected into the colon under a constant pressure, and that, unless the plate was pressed down on the colon, there would be a considerable spreading of shadow. The darkness on the right side of the U was also contributed to by the liver.

Dr. CAUFLEY supported Dr. Spriggs. He thought that a child with congenital dilatation of the colon ought to have a larger abdomen than the present child seemed to have. There might have been a temporary seemed to have. There might have been a temporary attack of dilatation from acute intestinal dyspepsia, which had now passed off. He did not understand why the case was spoken of as congenital, because even if there was dilatation, according to Dr. Carpenter the child was normally healthy until it got its attack of abdominal distension. And if a solution of hismath and storch was injected into a child's of bismuth and starch were injected into a child's colon, it would easily become dilated.

Mr. LOCKHART MUMMERY said the diagnosis could

be cleared up by the use of the sigmoidoscope.

Dr. CARPENTER replied that he still thought the colon was dilated, basing his diagnosis on rectal and bimanual examination, as well as on the X-ray picture. There was doubt about the thickening, and what else could it be due to? He would be glad to afford an opportunity for examination by the sigmoidoscope.

Br. CARPENTER showed a specimen from a case of "steeple skull" exhibited to the Section in December last. The child was at that time five weeks old, and died some little time after its exhibition. The specimen was the skull bisected in the median line.

The CHAIRMAN commented on the rarity of the condition, and said he believed there was no specimen of the kind in the College of Surgeons Museum.

Dr. CAUTLEY suggested that the specimen should be referred to an anatomist for report.

Dr. CARPENTER replied that he would not enter into a discussion of the skull before a full description had been written.
Mr. A. R. Thompson showed a case of

SOLUTION OF CONTINUITY OF THE RIGHT CLAVICLE since birth. The mother had fallen down some two weeks before the birth of the child. No deformity was noticed at birth. The boy showed a right clavicle which had apparently been fractured, the two portions being connected by a false joint, and forming an inverted V. Mr. Thompson thought the case was one of fracture, although such cases suggested the possi-

bility of cleido-cranial dysostosis

Mr. A. H. Tubby said this condition first came under his notice two or three months ago, in a child, aged 10 months. The labour had been a difficult one, the arms being behind the shoulders. On bringing the arms down, a distinct crack was heard, and there was found to be a deformity of the clavicle similar to that in Mr. Thompson's case. He operated and found an ununited fracture with a false joint, and wired the fragments together. He had seen a similar case, in which, despite wiring, no true union took place, and feared that in Mr. Thompson's case there would be no true union even if the false joint were excised.

Dr. Spriggs agreed that there was a fracture of the clavicle, and not cleido-cranial dysostosis. In most cases of congenital deformity of the clavicle of which he had seen photographs, there was evidence of defi-ciency of the membrane bones. In a case, for instance, published by the late Mr. Walsham, and in the photographs of Dr. Carpenter's cases, there was evidence either of an unclosed fontanelle, a globular cranium, a high-arched palate, irregular teeth, or some deformity of the lower part of the sternum. The present case showed none of these. Again, in cleidocranial dysostosis, although there was usually some irregular deformity of the clavicle on both sides, the fragments might be joined together by a loose joint, in which case the two parts fixed themselves in the same position as in this case. The case was an interesting one, historically, because a number of

cases of cleido-cranial dysostosis had been recorded as fractures even when the deformity was bilateral. Some anatomists, such as Paterson, of Liverpool, thought that the clavicle might be developed in two

The CHAIRMAN expressed his agreement with those who had spoken. He thought that operation should be undertaken.

Dr. E. I. SPRIGGS showed a case of MULTIPLE EXOSTOSES.

The boy came to St. George's Hospital in 1902, æt. 5, with a painful tumour in the upper end of the left tibia. At that time he showed several other small exostoses. Five years later, at the age of 10, he came to the Victoria Hospital, and then showed exostoses of the victoria riospital, and then showed exosioses of the vertebral border, of both scapulæ, and one on the spine of the right scapula, at the insertion of the pectoralis major, in the right humerus, at the lower end of both radii and ulnæ, on the left metatarsal, on the femora and tibia, and at the inner and outer ends of each clavicle. At that time he had a good deal of pain, and could not dress without assistance. Muscular power was fair. At present, two years later, the bony tumours were definitely less marked. The case was interesting as showing a few tumours at the age of 5, more at the age of 10, and a diminution in

their relative size since.

Dr. Milligan read a paper on a case of MENINGITIS ASSOCIATED WITH THE LEPTOTHRIX BACILLUS.

A child, aged 41 months, was admitted to hospital with a history of a fall on the head three days previously. There was general rigidity, conjugate devia-tion of the eyes to right or left, with lateral nystagmus. Craniotabes was present, and a bulging anterior fon-tanelle. Temperature, 101°, and pulse 104. A milky fluid was withdrawn by lumbar puncture, which contained an excess of polymorphonuclear leucocytes and a leptothrix bacillus, of which a photograph was shown. The organism was Gram-negative, and no growth was obtained either on agar-agar or blood The illness ran an acute course, the child serum. having a varying temperature, and dying on the fifth day after admission. A sub-dural meningitis was found post-mortem, extending over both hemispheres, especially over the vertex in front. There was an extravasation of blood on the side of the skull on which the child had fallen. The meninges were congested. Examination of the pus revealed the presence of diplococcus pneumoniæ. On opening the right ear, a small bead of pus welled up. A case of pyæmia and meningitis associated with a pathogenic leptothrix bacillus had been described by Ritchie and McDonald, who also spoke of terminal pneumococcal infection. Dr. McDonald had recorded five cases in which he found organisms similar to those described above in an epidemic of cerebro-spinal meningitis, and had concluded that the leptothrix was not a contamination. Dr. Milligan thought that the presence of leptothrix was more easily explained as a secondary infection, as this bacillus does occur about the mouth and throat.

Dr. CAUTLEY said that the important point was whether leptothrix was a cause of meningitis or a secondary infection. He had seen many cases of meningitis of that type, but without the leptothrix bacillus. The clinical course seemed to point to a pneumococcal infection.

Mr. N. BISHOP HARMAN read a paper on THE EFFECTS OF SCHOOL LIFE ON THE VISION OF THE CHILD.

After reviewing previous statistics, he communicated the results of the examination of 1,100 children, seen at the Belgrave Hospital and the Middlesex Hospital. In all cases the eyes were under the influence of atropine the ointment of 1 per cent. having been used four times a day for a week. Of every 100 children with defective vision, over 71 had hypermetropia, and less than 29 were myopic. These 100 children represent about 100 per cent. of the school children, and so the incidence of myopia amongst school children in London may be considered not to exceed 3 per cent. About 78 per cent. of the cases were girls. This Mr. Harman attributed to the girls having less outdoor exercise, and not being in such a healthy condition,

as well as to the fine needlework done in school by the girls. During the school age the incidence of hypermetropia increases, as may be expected from what we know of the growth of the crystalline lens. At the same time, the curve of myopia rises upwards to the highest positions on the chart, and such a phenomenon as this leads to the conclusion that the diminution of the hypermetropic astigmatism has been due to the transference of these cases to the myopic group. On the whole, the condition of the eyes of London children is very fair, especially if we compare them with similar returns collected in Germany. greater proportion of the cases of bad vision are due to natural conditions of the eye—that is, hypermetropia and hypermetropic astigmatism. New-born infants are always hypermetropic. The incidence of "manufactured" bad vision—myopia and its associated astigmatisms—forms between a quarter and a third of the whole of the cases. The evidence of the deterioration of astigmatic eyes indicates the desirability of a special oversight of these cases. Mr. Harman did not think that a healthy school life was harmful to the sight of the child population. In con-clusion, Mr. Harman criticised adversely the paper on the "Inheritance of Vision," by Amy Barrington and Earl Pearson. Several points in his experience led him to different conclusions. Miss Barrington and Prof. Pearson would lead us to suppose that the increase of myopia was due to fate, and hopeless, but in practice we find that the amelioration of school conditions and the relief of strain in ill-shaped eyes does stay the increase.

Mr. SYDNEY STEPHENSON congratulated Mr. Harman upon the clearness of his exposition. He agreed that it was futile to examine children's refractions unless the accommodation had been paralysed by atropine. Some years ago he examined 6,000 eyes, under the Poor-law, in children ranging from 18 months to 16 years of age. In these he found myopia present in 6.68 per cent. That was not very different from Mr. Harman's figures when the different range of ages was considered. He agreed that among the poor children of this country myopia was not of serious frequency. In his own figures the females were almost twice as much subject to myopia as were the males. He agreed in ascribing this to their employment in indoor work and lack of healthy exercise.

Mr. ERNEST CLARKE said that, although the subject was a tempting one, he would confine himself to reiterating what Mr. Stephenson had said as to the great importance of Mr. Harman insisting on the use of a cycloplegic. The statistics concerning the refraction of young people which were published without such were useless.

#### LIVERPOOL MEDICAL INSTITUTION.

THE LAST MEETING OF THE SESSION WAS HELD ON THURSDAY, APRIL 29TH

The President, Mr. T. H. BICKERTON, F.R.C.S., in the Chair.

#### SERUM TREATMENT OF TETANUS.

Dr. LLDYD ROBERTS reported a case of tetanus which had recovered under treatment with injections of carbolic acid and of anti-tetanic serum. The disease followed an injury to the hand from a circular saw. Symptoms appeared 10 days after the accident, and treatment was commenced on the 6th day of the disease. On the 4th and 5th day the symptoms had rapidly become more severe, and on the 6th day there was marked trismus, etc. The patient received 10 cc. of serum every 12 hours, and 15 minims of a 4 per cent. solution of carbolic acid every 3 hours for 1 day, and subsequently every 2 hours. On the second day of treatment the disease appeared to be arrested, and the patient was well 20 days later. Twenty-six injections of the companion of the second day of treatment was well 20 days later. tions of serum, and 236 injections of carbolic were given. The favourable result was attributed to the carbolic rather than to the serum.

Mr. Kelly referred to the prophylactic doses of

serum, and the value of intradural injections.

Dr. JOHN OWEN and Mr. DOUGLAS-CRAWFORD read a note on a case of

INTRASPINAL TUMOUR

which they had had under their care. It was localised at the 8th dorsal segment, and was successfully re-moved, the patient being shown at the meeting. They hoped to publish a full account of the case later.

Dr. W. B. WARRINGTON discussed the rarity of these cases, and urged the importance of physicians having sufficient faith in their diagnosis to urge an operation. Drs. Marsh and O. T. Williams read a paper on MENINGOCOCCIC MENINGITIS IN CHILDREN.

They referred to the importance of lumbar puncture in the diagnosis of tubercular meningitis from other types of the disease. In the last 14 cases of tubercular meningitis they had recovered the tubercle bacillus from the cerebro-spinal fluid. Four cases of tubercular meningitis with secondary meningococcic infec-tion were described in detail. The use of Flexner's serum had reduced the mortality from between 70 and 80 per cent. to 29.6 per cent. In children under two years the mortality was 42.4 per cent. in 59 cases, and in these the higher mortality was amongst those not treated until the seventh day of the disease. The serum was described, and its effect both on the organisms and the cytology of the fluid; being bactericidal and only slightly anti-toyic the serum must tericidal, and only slightly anti-toxic, the serum must be injected into the spinal canal. Fourteen cases of cerebro-spinal meningitis were considered. They varied in age from 3 months to 4 years, and 7 re-covered. Three cases treated in the first few days of illness all recovered. The amount of serum used in each case varied from 10 cc. up to 130 cc., and the number of injections from 1 to 5. In infants they advised small doses of 10 to 15 cc. Dr. Flexner confirmed this view. In older children they followed Dunn, of Poston, and gave 30 cc. on four successive days, the results upon symptoms and the fluid guiding their future procedure. They considered that this serum in carly cases promised extremely good results, and even in later cases it favoured the prognosis.

Dr. Owen referred to one case he had treated with

Flexner with satisfactory results.

Dr. Gullan referred to two. In one the fluid was not typical, nor was the diplococcus found. The patient recovered with Flexner. The second case, a girl of 18, had been ill a fortnight. After the first injection the patient passed into a state of coma, and, in spite of further lumbar punctures and injections, died.

Dr. John Hay referred to the occasional difficulty of differentiating in certain cases between acidosis and meningitis, and related a case illustrating the point.

OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY. NORTH OF

MEETING HELD AT MANCHESTER, APRIL 23RD, 1909.

The President, Dr. J. W. MARTIN (Sheffield) in the Chair.

A VOTE of condolence to the family of the late Mr.

Simeon Snell, proposed by Dr. LLOYD ROBERTS, and seconded by Mr. R. FAVELL, was passed.
Dr. H. BRIGGS (Liverpool) showed two specimens of

hæmatometra removed by the abdominal route. In each case the retention of menstrual fluid was due to congenital atresia of the cervix. The patients were unmarried women, set. 32 and 35 respectively. Microscopical examination of the uterine wall showed a great excess of fibrous tissue, and an absence of the glands of the endometrium.

Dr. A. DONALD (Manchester) read notes of a case of "Bilateral Abscess of the Uterine Appendages" occurring during pregnancy. Three weeks after spontaneous premature delivery, each abscess was drained extraperitoneally through an anterior colpotomy incision.

A marked improvement in the patient's condition immediately followed, but, two weeks later, symptoms of acute peritonitis appeared. On opening the abdomen a ruptured pyosalpinx was found and removed. Since then the patient has made a steady recovery.

Dr. J. H. WILLETT (Liverpool) showed the specimen from a case of "Cæsarean Section and Abdominal Hysterectomy" for carcinoma of the cervix, complicating a 7½ months pregnancy. The patient was a cating a 7½ months pregnancy. The patient was a multipara, æt. 34. Irregular hæmorrhage commenced at the end of the first month; later the discharge became offensive. The vagina was divided between clamps, but no attempt was made to excise the pelvic connective tissue. No enlarged glands were found. The mother made a good recovery, but the infant died when about four weeks old.

Dr. W. BLAIR BELL (Liverpool) read the notes of a case of "Acute Puerperal Sepsis with Thrombosis of the Ovarian Veins," which were ligatured and excised without success. Death occurred 16 hours after the operation. The details of a very complete bacteriological study of the case were given. Dr. Bell was of opinion that when septic thrombosis of the ovarian veins is diagnosed, immediate ligation and excision

should be practised.

The President, and Drs. Briggs, Donald and Lea

argued that the operation in such cases is useless.
Dr. A. DONALD (Manchester) read a note on the use of gauze drainage in certain cases of puerperal sapræmia, in which retention of lochia occurs from sharp anteflexion of the uterus with sagging of the body. Toxemic symptoms due to decomposition generally arise on the eighth or ninth day, or soon Immediate improvement follows intra-uterine douching, but renewal of the retention and of the symptoms is apt to occur. This is best avoided by the use of a gauze drain.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

#### FRANCE.

Paris, May and, 1989.

TREATMENT OF OBESITY.

THE treatment of obesity consists chiefly in a régime which the patient finds as irksome as complicated. For this reason few have the courage to persevere until a practical result is obtained. Dr. Moritz recommends a more simple treatment, quite as effectual; he has shown that an exclusive milk diet, varying between one to two and a half quarts a day is quite sufficient for the end in view.

Patients submitted to this cure do not suffer, in spite of the small quantity of nourishment ingested, from the disagreeable sensation of hunger experienced in following the other methods. Neither are they troubled by thirst, for they may allay it by adding water to the milk or taking water alone; but, in either case, the total quantity of liquid must not exceed two quarts a day.

This milk \*fgime is particularly beneficial in cases of obesity complicated with cardiac or renal lesions. Under its influence the heart troubles are soon relieved. the arterial tension is lowered and the frequency of the pulse diminished.

LINBAR CICATRIX AND TINCTURE OF IODINE. Every surgeon knows that incisions which heal by first intention under an antiseptic dressing and completely sheltered from all sepsis, do not always give that linear cicatrix desired both by the patient and the surgeon.

Din removing the sutures from the wound after 8 or 10 days the edges, although carefully adjusted, are frequently found to be somewhat separated super-ficially; a small fissure is the result, it granulates, and is finally transformed into an irregular cicatrix.

If the sutures were left in situ, a linear cicatrix would also be obtained, but leaving the marks of the

On the other hand, by observing what takes place during the healing process of an ordinary cutaneous wound, it is frequently found that the wound which did not appear very satisfactory on account of slight signs of irritation presented, furnished in the end a very good cicatrix, almost as fine as the scratch of a needle. Consequently, to obtain an æsthetic cicatrix, it is well to provoke a slight irritation of the edges of the incisions.

For this, says M. Schwarz, there is no better means than tincture of iodine. He has had recourse to this treatment for several years, and with constant success. He paints the surface with the tincture after the third or fifth day, and repeats the operation during two or three successive days. Small incisions require only one coating of iodine.

Prof. Grossich uses tincture of iodine exclusively for disinfection of the skin in every case of operation, and finds it superior to all classical methods; it has

also the advantage of great simplicity.

On the eve of the operation the patient takes a bath and, without further toilette of the skin, the region is rubbed with a plug of cotton steeped in tincture of iodine of 12 or 15 per cent. When the operation is terminated, the application is repeated along the line of ligatures. In this way M. Grossich practised over 50 operations, including the radical cure of hernia, kelotomy, amputation of extremities, laparotomy, ovarian cysts, etc., and the results were so satisfactory that for him, tincture of iodine represents the best method for disinfecting the skin and constitutes an excellent resource in urgent operations.

TODEIN OR BI-IODIDE OF CODEINE.

Experiments made in the Paris hospitals have shown that iodein possesses indisputable properties in broncho-pulmonary and cardiac affections, acting as a sedative on the cough and as an expectorant. No drug, it would appear, possesses in an equal degree such a sedative action on the mucous membrane of the larynx and the bronchi. The effect is so rapid that the most violent fits of coughing frequently yield to one or two spoonsful of syrup of iodein.

In pulmonary emphysema iodein rapidly relieves dyspnœa in freeing the bronchi more or less clogged

with mucus.

Bi-iodide of codeine give equally favourable results It has also been successfully used in in asthma. acute or chronic bronchitis, cedema of the lungs, etc.

The drug establishes better ventilation of the lungs by increasing the amplitude of respiration and in regulating the respiratory rhythm. It is thus that a large volume of air penetrates into the alveoli of the lungs through the congested bronchi, diminished in calibre by inflammation of the mucous membrane and the accumulation of pathological secretions; hence, a greater facility of interchanges with disappearance of suffocation and dyspnga and the patient

experiences a sensation of agreeable relief.

Iodein may be prescribed for months without producing any evil effects, nor is it necessary to increase the doses; the same doses taken by the same patients

always produces the same results.

Hæmatemesis.

Gelatin, 4 dr. Boil six hours in 5 ozs, of water to ensure liquidity. Add syrup of lemon, 1 oz. A tablespoonful every two hours.

## GERMANY. Berlin, May 2nd, 1909.

RENAL NEURALGIA. A CASE of this is described in the Münch. Med. Wochsch. by Oberarzt Dr. Urban. A woman, set. 26, was admitted into hospital for gall-stone colic. Attacks of biliary colic were said to come on every three weeks; calculi were also said to have been seen in the stools. There was a permanent dull pressure pain in the right side of the body, especially about the loins. There were violent attacks of pain in the right hypochondrium, beginning above and radiating backwards. The internal organs were healthy; the urine also was free from any morbid contents; there were no signs of hysteria. An operation was performed four days later, but nothing was found. Then there were pains about the cæcum, with rise of temperature (39°). Six weeks later the appendix vermiformis was removed. Adhesions and a small quantity of pus were found. A fortnight later there were complaints

of pain in the lower part of the abdomen. Repeated Rontgen illumination showed that there were no cal-culi. A third operation was performed four weeks later—viz., decapsulisation of the right kidney. The next day the pain and feeling of pressure in the right side, that had tormented the patient for a year and a-half, had disappeared. She was then quite free from pain, and looked in blooming health. Her weight, which at the time of the operation had been 48 kg., rose to 85 kg. in the course of a few months. In the Med. Klinik, Dr. E. Schlesinger lays down the limit set the

the limits of the

INJECTION TREATMENT OF NEURALGIAS.

He says that acute sciatica in all cases, and chronic sciatica in most, are not a field for treatment by injection. Rest in bed, quinine in small repeated doses, and galvanisation frequently lead to the desired result. In case of coincidence of sciatica with the uric acid diathesis, a strictly vegetable diet must be carried out. Treatment by injection is by no means a universal form of treatment for all forms of neuralgia. If a judicious choice is made by the physician, however,

it will rarely fail to satisfy expectations.

THE TREATMENT OF PLACENTA PREVIA
is discussed by Dr. M. Henkel in the Arch. f. Gyn., 86, 3. A considerable part of the puerperal mortality rests on placenta prævia, usually the central kind. By the usual treatment 50 per cent. of the children born at the end of term are born alive. When the cervical canal is closed, a tampon or a rubber ball is generally introduced into the vagina. Before the tampon is introduced the parts are shaved and well disinfected. Tamponade with gauze is the best, which has been soaked in a 2 per cent. solution of alum. If the liquor amnii has escaped, tamponade is no longer of use. Turning and metreurysis are now called for; the latter may, however, cause fresh bleeding. If the bleeding has already been excessive, but little more is required to bring on such a condition of anæmia that life can be no longer maintained. With a one-finger os uteri the writer performs turning in the following manner: Guided by the finger, the toes of the fœtus manner: Guided by the inger, the toes of the fætus are grasped by a pair of forceps. Digital dilatation is only suitable for the experienced obstetrician. Dilatation by Bossi's method has many disadvantages.

THE TREATMENT OF ECLAMPSIA is the subject of a paper in the D. Med. Wochensch., by Dr. Reifferscheid. In his last 30 cases delivery was effected immediately. The mortality was a part

was effected immediately; the mortality was 20 per cent., and thus far greater than by the expectant method. If the 15 cases were taken in which delivery was effected after the first attack, the mortality was 13 per cent. If the 6 cases were taken in which the birth of the child was spontaneous, or in which the first attack came on after delivery, the mortality was 23 per cent. The child mortality was much more favourable by careful artificial delivery than by the waiting method—viz., 20 per cent., against 40 per cent. by the latter method. The writer's advice is to operate at once, without narcotics or any sweating treatment, as this can only result in thickening of the blood; but he would bleed, give oxygen, or, if the attacks first came on during child-bed, he would perform decapsulisation of the kidney.

# AUSTRIA. Vienna, May 2nd, 1909.

CHRONIC HEPATITIS.

FLECKSEDER exhibited four preparations at the Gesellschaft für Innere Medizin of chronic inflammation of the liver. In all of these he found the status infantilis present, and asked the question if this condition were always present at the inception of hepatic inflammation? The first example was alcoholic cirrhosis in the hypotrophic stage; the second cirrhotic tubercular atrophy; the third biliary cirrhosis, ætiology uncertain; and the fourth a diffuse form of intra-hepatic cholangitis, probably arising from the bacteria coli. In all the four there are marked signs of infantilism, or lymphatic hyperplasia, but in most of them these were combined. This infantile state was also marked in the external genitals as well as the internal by the hypoplasia of the gland, want

of hair, smallness of the head and thyroid gland, as a narrowing of the vessels which seemed to be associated with hypoplasia of other tissues. From these conditions he reasoned that the lymphatic glands and liver suffered in the same way by these changes in the liver, or vice versā. He therefore contended that there was a period of pseudo-hyperplasia preceding genuine hyperplasia which established a low resistance against the various noxa. This individual infantile disposition of the liver opened up a wide question for investigation, and might greatly assist clinical work if a clear conception of the relationship did exist.

Bauer said that one of these cases, the alcoholic cirrhosis, had been treated in his clinic, and thought it right to mention that one of the prominent symptoms in the history was alimentary galactosuria. This patient eliminated from 10.8 grammes to 40 grammes of galactos in the urine in 24 hours.

OSTEO-ARTHROPATHIE HYPERTROPHIANTE

PNEUMIQUE. Bondl presented an interesting case of bone and joint affections succeeding thoracic empyema. patient, a young man, æt. 26, was operated on in 1907 for empyema, when several of the ribs were resected. After the operation a fistula was formed, from which a constant discharge exuded. To check this secretion two thoraco plastic operations were performed, without success. The figural is still present in the left side and the secretion profuse. In the autumn of 1908 the patient commenced to feel pains in the hands, ankles, and other joints, and when examined found the distal ends of the long bones greatly thickened, forming knobs. With the Röntgen rays this increase was found to be an apposition of new bony substantia compacta of the long bones, well marked in the metacarpal and metatarsal bones.

GASTRIC ADHESION. Politzer presented a female, æt. 24, in whom the stomach and colon became united, and were afterwards relieved by operation. Shortly after the flexura hepatica coli became bound up with the pars pylorica of the stomach with stenosis of the pylorus. this condition a rhythmic, intermitting rise and fall of the hydrochloric acid took place in the stomach, with the appearance of sarcinæ. Schmidt remarked that severe pyloric stenosis was always associated with sarcinæ, and where the pyloric stenosis was moderate or slight, the presence of sarcinæ was intermittent, which seemed to run parallel with the congestion of the stomach.

#### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

EDINBURGH POST-GRADUATE COURSE.—The post-graduate course in medicine, which has proved so successful during the past three years, will again be given this autumn. It runs from August 30th to September 25th, and comprises (1) a daily special lecture on some subject of general interest; (2) a general course; (3) special courses on bacteriological and other practical work; (4) a surgical course. The syllabus has been issued, and may be obtained from the Secretary, Faculty of Medicine Office, University of Edinburgh. Early entry should be made for the surgical course, or any of the limited classes, as it has been found in past years that these sections of the course soon fill up. Women are entitled to attend the course. The University Union is open to members on payment of a small fee, and arrangements have been made permitting those attending the course to board in the University Halls of Residence.

GLASGOW ROYAL INFIRMARY.—Dr. J. H. Teacher has been appointed Pathologist to the Royal Infirmary, Glasgow, on the resignation of Dr. Galt. Dr. Teacher is the Lecturer on Pathological Histology at the University, and is assistant Pathologist at the Western Infirmary and Sick Children's Hospital. His important work on chorion-epithelioma is well known. There was an unusually keen competition for the position, in view of the pending change in the relationship of the Royal Infirmary to the University. There is it seems, considerable prospect of a new chair of

pathology being instituted in the Infirmary.

Edinburgh University.—Professor Chiene has received further leave of absence from the University, and during the summer Mr. Wallace will carry on the class of operative surgery, and Mr. Alexis Thomson the clinical work associated with the chair. Although Mr. Chiene is not yet able to resume his duties, his friends will be glad to learn that his health shows considerable improvement.

GRANTS TO SCOTTISH UNIVERSITIES .- The Treasury Committee appointed to consider the claims of the Scottish Universities to additional State assistance, visited Glasgow some weeks ago, and are expected to make a tour of inspection of the Edinburgh school this month. It is understood that the bulk of the committee's work in the way of hearing statements will be done in London. At present the Scottish Universities receive £40,000 from the Treasury, and the inadequacy of this grant has for long been a grievance.

DR. STUART McDonald, lecturer on Pathology in the New School of Medicine, Edinburgh, and Pathologist to the Children's Hospital has been appointed to the post of Pathologist to the Royal Infirmary, Newcastle-on-Tyne. Dr. McDonald is one of the most popular teachers in the Extramural school, and his departure from Edinburgh is greatly regretted. He has taken a leading part in all questions concerning the improvement of the medical curriculum, and is a most enthusiastic worker in pathology. His friends in Edinburgh feel that the Newcastle authorities have been fortunate in securing his services.

#### LETTERS TO THE EDITOR.

 $[\mbox{We do not hold ourselves responsible for the opinions expressed by our Correspondents.}]$ 

#### THE PROVIDENT DISPENSARY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-Those who complain of the hard times to which the medical profession is subjected, but who are content to sit still with folded hands when reform is mooted, should think over problems such as those raised by Dr. George Crichton in your issue of April 28th. Whether we agree with that gentleman's views or not, we should all be grateful to him for bringing forward practical points for discussion in a clear and crisp manner. Personally, as a medical practitioner of many years' standing, I am no less opposed to the provident dispensary than to the free and unchecked free hospital system. Both constitute in my opinion gross forms of competition with a highly-skilled and underpaid profession. The fact that a few pence are paid by the patients in the provident dispensary may save their faces, but it none the less leaves the door open to abuse as great or greater than that which has grown to such an enormous extent in the hospitals. Indeed, when the latter exact fees from patients, as some of the largest and wealthiest hospitals do not hesitate to do, the difference between the voluntary hospitals and the provident dispensaries is much like tweedle-dum and tweedle-dee. If anything be charged at all by a so-called charity, it should in no case be less than the minimum fee charged privately by outside practitioners to persons in a corresponding class of society. I trust some of your readers will furnish Dr. Crichton with the necessary data for a further communication, in which he will analyse with his usual

logical precision the present situation.
As for myself, I think all charity should be pure charity, and that no payments by patients are under any conceivable circumstances justifiable. How does that view of the case commend itself to Dr. Crichton?

I hope, Sir, that you will encourage in the columns of your valuable journal questions that are of practical importance to the rank and file of the noble pro-fession to which we are proud to belong. But mere

nobility butters no parsnips, and it is a sad irony that saddles the efforts of philanthropy with cramped homes and starved professional means.

I am, Sir, yours truly,

G. P. OF MANY YEARS STANDING.

Birmingham.

GENERAL PRACTITIONERS AND MIDWIVES. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-In Dr. G. de G. Griffith's letter I fail to see a reply to mine. A minor point raised in my letter is briefly noted, and I am informed that information on the point can be obtained from agents. The vital points raised are unanswered. The letter is really a very spirited missionary appeal. Now I can fully appreciate Dr. Griffiths' lament over the lack of medical below in foreign lands but also I fail to see medical help in foreign lands, but, alas! I fail to see why the medical and surgical treatment of even the most heathenish of the heathen should be entrusted to quacks whom we should not tolerate for one moment in England. When we consider the enormous sums of money which are annually spent on Foreign Missions, one wonders if a considerable sum would not be well spent in sending out duly qualified men and women to attend to the bodily ailments of these unfortunate human beings. Two quotations seem to me rather apt when considering this question. Salus populi suprema lex, and Mens sana in corpore sano. We are so imbued with the idea of "saving souls" that we are apt to disregard the temple containing those souls (the body). I shall not trouble you with any further communication upon this subject, as I have achieved my chief the containing the soul of the containing the soul of the containing have achieved my object in pointing out the features in Dr. Griffiths' communications to which a general practitioner having the best interests of his profession at heart must object.

I am, Sir, yours truly,

S. J. Ross. Monkhams, Bedford, April 28th, 1909.

"POST-OPERATIVE TETANUS" OST-OPERATIVE TETANUS" AND POST-OPERATIVE SCARLATINA SYMPTOMS. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In looking over your Journal for April 28th, 1909, I read the article on "Post-operative Tetanus," and it calls to mind the cases to which Sir James
Paget drew attention, of scarlet fever attacking his
patients after operation. When I read the report of patients after operation. When I read the report of those cases I drew Sir James Paget's attention to the fact that though apparently scarlet fever, they were really cases of septicæmia producing the redness and other symptoms so strongly resembling those of true scarlatina.

In was in 1875 that I read a paper at the Obstetrical Society showing that what was considered to be scarlet fever attacking the puerperal patient was not scarlet fever at all, but the result of sepsis other than scarlatina, and that no evidence of scarlatina having been brought to the woman could be traced, and that all the circumstances and conditions surrounding her precluded the probability and possibility of contagion from scarlatina.

I remember that before we could be admitted into the operating theatre when certain operations were being performed we had to sign a book, or make the statement, that we had not been in contact with or near any such contagion as scarlatina, which was looked upon as the worst foe, and was the dreaded enemy of the puerperal woman. In my paper I termed the symptoms "bastard scarlatina," inasmach as, though resembling scarlatina, they are another source of blood-poisoning altogether. arose from

The first patient whose symptoms called my attention to the origin of those cases of "bastard scarlatina" was a lady whom I attended in Blackheath. I could not see her every day, and in my absence a clot had formed in the uterus, and some absence a clot had formed in the uterus, and some decomposition had begun. When I got down the nurse told me she was afraid the lady had scarlatina. I examined, and feared so also. I then palpated the abdomen, and on turning up the bedclothes to do so noticed an unpleasant odour. Finding the uterus enlarged, I pressed on it, and expressed a large clot,

which was fœtid. Having done this, the vagina was well washed out, till the water returned quite free from smell.

The douching was repeated daily till it was longer necessary; and the scarlatina symptoms disappeared so quickly, that it caused me to ask myself the question, Was it scarlatina at all, or was it wholly produced by the decomposing clot? We made most particular inquiries re scarlatina, and came to the conclusion that that ailment was not the origo mali, but that all the symptoms were blood-poisoning from the decomposed clot, and observation of cases recorded in the intervening years have proved the correctness of the diagnosis.

At the Obstetric meeting to which I refer Dr. Priestley was in the chair, and Dr. Robert Barnes and Dr. Braxton-Hicks sat on the bench behind me.

I am, Sir, yours truly,
G. DE G. GRIFFITH.

London.

THE BIRTH-RATE QUESTION AND FRENCH DEPOPULATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—To those of your readers who may care to learn what is thought by responsible French statesmen of the position of their country in face of a diminishing population, brought about by the deliberate action of the whole people, I commend the perusal of an article in the Reveue Blew of April 24in from the pen of M. Paul Strauss, Member of the Senate. If the breeding of the race could be organised on exact scientific lines, based upon prudence, and guided by the teachings of established knowledge—an guided by the teachings of established knowledge—an aspiration at present purely Utopian—the causes for anxiety need not exist, and the French would not be faced by what M. Strauss describes as the "agonising problem" of the day—the question of the existence of their country as an independent Power. Every year that passes makes France inferior to Germany; she could not now defend herself in a "fight to a finish"; she has only 39,000,000 of people against 65,000,000 to draw upon. History repeats itself. A great, virile race, in contact with a dying people, has always in time conquered or devoured its weaker neighbour. Germany will need room for her million annual increase, and although she may not demand French territory, she will surely make France, sooner or later, yield up all her oversea possessions, which, from the population point of view, are entirely useless to her. Germany, when the time arrives—when her statesmen believe the moment has come for action can march in and seize and hold French soil until her demands are acceded to. There would be no Power or coalition of Powers capable of effectual interference, even if Austria was not, as she is, bound to Germany by hoops of steel—bound not only by gratitude, but by the imperative necessities of her own situation. Surely all this forms an object-lesson for ourselves. We are following the example of France. I have in previous letters explained how our course must prove more rapidly disastrous to ourselves than to our decadent neighbour, but there is as yet no sign of recognition of these facts by our people or their responsible leaders.

I am, Sir, yours truly,
A STUDENT OF SOCIOLOGY.

April 28th, 1909.

#### **OBITUARY.**

GEORGE ROE CARTER, M.R.C.P.I., L.R.C.S.I.

WE regret to record that Dr. George Roe Carter. Medical Officer of Health of the Penge District Council, died on April 26th at his residence at Anerley. where for the last 30 years he had an extensive practice. Dr. Carter spent the earlier years of his professional life at St. Lucia, West Indies, where he was Colonial Surgeon and Medical Officer of Health to the island. He was educated at Ledwich School. Dublin. At Meath Hospital he was awarded a prize

for his surgical work, and he afterwards became House for his surgical work, and ne alterwards became House Surgeon to the institution. He was also a Fellow of the Royal Institute of Public Health, and an exmember of the Councils of the British Gynæcological Society and the Irish Medical Graduates' Association. His qualifications, which were obtained in Dublin, in-cluded the membership of the Royal College of Physicians and the Licence of the Royal College of Surgeons. Dr. Carter was born in 1843.

# MILITARY & NAVAL MEDICAL

It is reported that motor car hospitals will be given exhaustive trials at the German autumn manœuvres to take place in Wurtemberg. If the results are satisfactory they will be introduced into the Army. These motor car hospitals are designed to move from position to position with the firing line with much greater tion to position with the firing line with much greater ease than the ordinary ambulances. They are to be equipped with medical and surgical appliances and capable of conveying wounded men—ten or twelve—quickly and comfortably to field hospitals from the field of action.

Some friction has arisen between the War Office and Mr. Sydney Holland, of the London Hospital, regarding the method of recruiting for the Territorial Nursing Reserve. Mr. Sydney Holland explains matters in a letter to the *Daily Telegraph*. Two very pregnant sentences appear in this letter, which are these:—(r) "Is it not curious that in every war so far the nursing arrangements of the War Office have broken down, and they have had to come to civilians to help them out?" (2) "And yet, here again, when in time of peace, arrangements are being made, the War Office go right against the opinions of those whom they have selected and those who have been appointed to advise them on nursing matters because of their special knowledge."

THE reduction of the military force in South Africa, and also the now almost complete immunity of the troops in Malta from the fever which was so prevalent at that Mediterranean station, and went by the name of "Malta fever," has been the means of bringing home several (some 20) full pay Medical Officers, who have to be provided with billets at home. This has necessitated dispensing with the services of a number of retired pay Army Surgeons who had held recruiting appointments in the London District, and elsewhere, for several years. The disappointment to the retired pay officers was very great, but the Director-General of the Army Medical Service, Sir Alfred Keogh, with his usual thoughtfulness and consideration, has offered some of these retired officers stations where civilian practitioners had been employed, e.g., Nottingham, Sunderland, etc. Employment for a retired pay Medical Officer means £150 per annum, added to his retired pay, which is by no means to be despised. So keen is the competition by retired officers for any billet carrying this extra emolument that it is well known at headquarters that there are 30 applicants for every vacancy. As a rule, it is more economical to employ retired pay medical officers at £150 a year in stations than civilian practitioners drawing fixed sums per head of recruits examined or soldiers receiving medical aid. As the War Office has ever an eye to economy, it explains why some retired Army Medical Officers have been offered stations which have been served by civilians up to the present.

THE Army and Navy Gazette states that it is not generally known that the Secretary of State for War was questioned by Mr. Lupton, M.P. for Sleaford, on the subject of enteric fever. Mr. Haldane's reply, which bears on a very important matter, viz., inoculation for this fever, stated that in the last year arrangements had been made for the voluntary inoculation against enteric fever of officers, warrant officers, N.C.O.'s and men of the Regular Army at all stations at home prior to their departure for foreign service. Arrangements, he said, had also been made for

voluntary inoculation against typhoid (enteric) fever being carried out on board all troopships, and in all commands, including India where enteric is preva-lent. Statistics on the subject are not yet available. No arrangements have been made for the voluntary inoculation of the Territorial Force in this country. These inoculations are performed by officers of the R.A.M.C. The anti-typhoid vaccine is prepared at the Royal Army Medical College.

A LETTER appears in the Naval and Military Record, of April 15 headed "Sisters in Royal Naval Hospitals." It is signed "One Who Has Escaped." The letter gives a somewhat pitiable account of the work and the new regulations. In respect of the latter, the correspondent says: "The new rules seem to have been carefully framed to make the lives of the sisters as miserable as possible, without any corresponding benefit to the patients; in fact, the sister is so rushed with other duties that she has hardly any time to give to their individual care." The letter ends with a warning to any nurse who has the smallest chance of a sister's billet in a civil hospital not to join the navy under its present conditions, or she will bitterly regret it.

For the present Infantry Reservists joining the Royal Army Medical Corps will only be accepted for training at the following centres, viz., Aldershot, Chatham, Colchester, Dublin, and the Curragh Camp.

THE Indian Medical Congress, which was opened at Bombay on February 22nd, has proved an immense success from every point of view, and we hope to furnish our readers with some of the papers read thereat. His Excellency the Governor presided at the inaugural ceremony, and presented Major Ronald Ross, Captain Jones, I.M.S., Captain Nicholls, I.M.S., and Professor Ghujar with the coveted medals. Surgeon-General A. T. Sloggett presided over Section I., Surgeon-General Hamilton Section II., Surgeon-General Benson, Section III., Lieut.-Colonel Crimmin, Lieut-Colonel Dyson, and Dr. Turner presided over Section IV. alternately, and Surgeon-General Stevenson over Section V.

#### REVIEWS OF BOOKS.

THE DIAGNOSIS OF BACTERIA. (a) This small work supplies a long-felt want. Of books on bacteriology there are many, but what the student and practitioner often require is a handy volume such as this, which gives in condensed form all the information which the average student is expected to know regarding bacteria and their mode of recognition. The various bacteria are placed in groups, and their special characteristics by which they may be severally recognised are carefully indicated. To the average student the various characters presented by the pathogenic bacteria always form a difficult study, but the subject is treated so tersely in the book under review that the task of the learner is greatly simplified. The different staining methods are clearly set forth, without any unnecessary detail, and even the staining of spores and of flagella is referred Then follows an account of Widal's reaction and the opsonic index, while the various reactions used in the diagnosis of tuberculosis are all referred to with sufficient fulness. The mode of obtaining pure cultures is very accurately explained. A very useful section is the one dealing with sterilisation as applied to bacteriological work. The mode of conducting post-mortem examinations on inoculated animals is also referred to at some length. The volume concludes with a reference to spirochæta pallida, trypanosomes, and the organism of malaria. The volume is one which we can recommend with

It forms not only an excellent every confidence.

<sup>(</sup>a) "Differential Diagnosis of Bacteria and Bacteriology." By E. P. Minett, M.D., D.P.H., M.R.C.S., L.R.C.P., F.C.S., Assistant Bacteriologist and Demonstrator in Bacteriology and Microscopical Pathology to Guy's Hospital. Crown 8vo., pp. viii., 72. London: Bailliere, Tindall and Cox. Price 2s. 6d. net.

laboratory companion, but it may be used as an introduction to the study of bacteriological research. Students preparing for examination will also find this book of the greatest possible service, as it supplies an immense amount of practical information in a handy and easily remembered form. The author's statements are characterised throughout by accuracy and clearness, and altogether this little work is a most commendable production.

SPECIAL HOSPITALS. (a)

This monograph opens with an interesting historical sketch, which shows how the hospital took its origin in the Temples of Ancient Religion. These temples "were something more than places of refuge for the sick, they were sanctuaries for worshippers, seats of learning for the student, health resorts for the convalescent, and centres of recreation for the whole people." "Here the priest-physician treated disease, taught philosophy and continuation to the same treath of taught philosophy, and gave instruction in the sacred science of medicine." To the Greek especially health and religion were inextricably interwoven. Many of the Hellenic shrines were known as Temples of Health; sanctuaries were consecrated to Æsculapius, the God of Medicine, and to his daughter Hygeia, the Goddess of Health; Apollo was the Healing God. (It may be interjected here that the latest scientists regard him in the same light.) Mr. Kershaw traces specialism in medicine back to the earliest recorded times. "It was nowhere more developed than in the ancient Universities of Egypt, of Greece and of Rome. In Egypt the sacerdotal doctors divided the human body into thirty-six anatomical parts, each part being dedicated to its own special deity." Hippocrates tells us that in Greece a large proportion of the Temples of Health, presided over by the Asclepiadæ, and erected as receptacles for the sick . . . were built in the vicinity of therms or medicinal springs: "which method of treatment clearly demonstrates the existence at that time of hydrotherapy as now practised at our modern spas." Moreover, the Greeks and Romans had their oculists, as is proved by the inscriptions on ancient marbles.

Mr. Kershaw follows the development of specialism

through early Christian times, through the Middle Ages, to its climax in the nineteenth century. This chapter, it should be said, is admirably illustrated by woodcuts of ancient and mediæval subjects. Subsequent chapters deal with the origin and development of modern special hospitals in the United Kingdom, their advantages on the score of economy, their enormous value to medical education, and their freedom from abuse, in the matter of charity. The book contains some interesting statistics, and concludes with a list of special hospitals founded in the United Kingdom during the nineteenth century, giving the names of the founders, the number (during the year 1907) of medical visitors, of post-graduate students, and of patients sent by medical practitioners.

Mr. Kershaw, who has occupied the post of Secretary to the Central London Throat and Ear Hospital for many years, pays a tribute to the modern nurse, and to the work done by medical women who still have to face opposition in their career.

TREATISE ON CHEMISTRY. (b)

TREATISE ON CHEMISTRY. (b)

This well-known work, which first appeared in 1878, was reprinted in the following year, and again with alterations in 1883, 1887, and 1893, a new and entirely revised edition was issued in 1897, and the present issue published in September, 1907, is again entirely revised. In a work of this nature, dealing with an enormous number of details, processes, etc., both manufacturing and analytical, both of which are subject to continual variation and improvement as manufacturing and series of the series of ject to continual variation and improvement as manufacturing and analytical knowledge progresses there is always a danger that old matter from previous editions may escape alteration. After a careful examination of

that the various monographs have been well brought up-to-date in nearly all cases. Probably the reason which has compelled the exclusion of some of the recent information which the revisers would have been glad to include was the practical necessity of keeping the size of the volume (which now extends to over 1,400 pages) within manageable limits. The work of revision has been so well carried out that it is an invidious task to criticise what are, after all, minor details. Among a few other omissions, however, we would point out that the assay of wolfram for tungstic acid is dealt with in a very short manner, and the working details that should accompany it are wanting. Under the article on tin it is stated that "it has been found in small quantities in Siberia, Guiana, and Bolivia, in a native state—though, according to Forbes, that from Bolivia possibly may have been an artificial product." The probable explanation of all reported discoveries of metallic tin is that if not due to ancient smelting operations, the reduced metal has been produced by an accidental smelting due to bush-fires. The detection and assay of tin cassiterite is not at

the present edition we find that is not the case, and

all adequately dealt with, and no mention is made of the necessity for separating the black oxide by "vanning" by the gangue with which it occurs, which is the first step in assaying any ore for tin. The smeltmethod of assay by cyanide and the smelter's assay using anthracite are not given. The electrolytic methods for the recovery of tin from tin scrap of old "tin" cans is not dealt with, though this industry is now assuming considerable importance.

Turning to other articles, for example, those on gold, silver, copper, uranium, etc., the details given on the methods of assay extraction, etc., are much fuller and more up to date. For reasons of space, it seems that in the next edition it will be advisable to deal with the vast quantity of matter involved in two volumes rather than one.

The above criticisms must not be understood depreciating the immense value of this volume, which is a practical necessity to every working analyst. If the publishers were able to reduce the cost of the book, there are many men who would be able to add to their shelves who are debarred by the present price, and the increased sales that would unquestionably result would make it possible for revising to be undertaken at more frequent intervals to the increased benefit of all concerned

It is only by means of frequent issues that a work of this nature can be properly kept abreast of the perpetual changes and improvements that are almost daily occurring in methods of manufacture and analytical processes.

#### LITERARY NOTES.

WE can say without hesitation that Dr. Langdon Brown's "Physiological Principles in Treatment" Book on treatment that we have read for a decade. Without seeking to be exhaustive, or to rival the comprehensive text-books on the subject, this little work so happily combines the best of modern physiological thought with the most practical branch of medicine as to make the reader wonder why all physicians are not compelled to study pure physiology—supposed by many to be as useful a subject as pure mathematics or transcendental philosophy—as a regular daily pursuit. Dr. Langdon Brown has the rare accomplishment of being a first-rate physiologist and physician at the same time, and his teaching, much of it quite new, is that rational treatment must be founded on sound physiology; if not, either the treatment or the physiology is wrong. He develops his thesis with extraordinary care and skill, and which, to our mind, reaches their highest point in the chapters on digestance. tion. We venture to say this book will be a revelation to most readers, and they will never again prescribe mist. gent. alb. without the comforting thought in their mind they know why they are doing it, and what it may reasonably be expected to accomplish.

<sup>(</sup>a) "Special Hospitals; Their Origin, Development and Relationship to Medical Education. Their Economic Aspects and Belative Freedom from Abuse." By Richard Kershaw. Pp. 72. London: Geo. Pulman and Sons. Ltd.

(b) "Treatise on Chemistry." Roscoe and Schorlemmer. Vol. II., "The Metals." Pp. 1436, with many diagrams. London: Macmillan and Co., Ltd. Price 30s.

An ingenious, almost startling book is Dr. Rumley Dawson's "Causation of Sex" (H. K. Lewis). The work of a general practitioner who has taken twentytwo years developing his theory, collecting materials, and checking his conclusions, the volume is a credit to the enthusiasm and energy of the author, if it be nothing more. If Dr. Rumley Dawson is right, and if his conclusions are finally accepted, his name will stand with those of Jenner or Mendel; if incorrect, he will remain one of the very few men who have to penetrate one of the most tantalising arcana of Nature. Briefly the theory is that the male element has no influence in the determination of sex, the sexual properties lying entirely in the ovum; and, further, that the male ova are derived from the right ovary, the female from the left. As each ovary produces an ovum each month in alternate months, it is possible to predict, and indeed for the parents to decide on, the sex of the child. How Dr. Dawson works his theory out and the evidence he brings to bear on it, we must leave readers to find out for themselves. This they should be eager to do, for they may be reading the book of the century. As to that we reserve our own opinion.

No one who has read Dr. William Murray's "Rough Notes on Remedies" will be surprised that Mr. H. K. Lewis has issued a sixth edition. Dr. Murray is one of the lessening number of consultants who has not lost faith in drugs quad drugs. In an age of scepticism he preaches the old gospel which has stood so many generations of practitioners in good stead. "I myself have an undying faith in drugs, from a dose of castor oil to the newest synthetic compound with twenty letters to its name; and remember it is not always the impotence of the drug which causes failure, but the want of proper administration; therefore study the best methods of combining and administering your drugs." These are bracing words, and many examples of how the principle they teach are given in this little book. It is a book that should be given to the young who are emerging from the post-mortem room and the bacteriological laboratory, and feel the impotence of the Pharmacopeia to do battle with the hosts of Nature. And to the older generation it will do much to strengthen the muscles of their faith.

THE "Medical Annual" has become almost as much of an institution as the "Medical Directory," and although it has not attained the portentous size of its homologue, the growth in bulk and importance in-creases every year. We do not envy the editor his task of getting some forty contributors up to sending in their articles on the progress of medicine during the year in time to publish the annual, so that the reader can have it in his hands at the dawning of the next, but he certainly accomplishes it with great The list of contributors strikes us more by the inclusion of new names than by elimination of old ones, but it undoubtedly represents a strong and a catholic staff. The illustrations are well up to the best level of the art of reproduction in its modern developments, and such plates as the coloured ones of gastroscopic examination and diaphanoscopy of the eye leave nothing to be desired.

In this new volume of "The Medical Annual," Dr. Watson presents a series of plates to illustrate his article on "Nasal Accessory Sinuses" which in themselves are a joy to look upon. One of the articles which will attract most interest is that by Mr. Sampson Handley on his operation for lymphatic obstruction. Most surgeons are aware that Mr. Handley's method consists in burying a number of silk threads in the tissues leading from the affected area to a place where the lymphatic circulation is in active progress. The immediate success of the manœuvre is striking in its rapidity and efficacy, and Mr. Handley estimates that its effects should last for ten years. New methods of diagnosis and treatment of syphilis have led to an interesting article by Mr. Thomson Walker, and practitioners will do well to make its contents part of their own knowledge. Professor Lucas-Championnière has dealt in a most valuable way with the modern treatment of fractures, and, happily for patients, the modern treatment is very different from the old.

An important work, having for its object the elucidation of the working of the Workmen's Compensation Act from medico-legal standpoints is announced by Messrs. Bailliere, Tindall and Cox to be ready in a few days. There are many obscure points in the working of this Act, and medical men frequently find themselves in almost insuperable difficulties regarding them. them. To facilitate matters, chapters have been written by about thirty well-known medical authorities as to the effect of injuries to the various organs of the human body, whilst the legal side and the editorial work has been entrusted to the able hands of Mr. Douglas Knocker, barrister-at-law.

THE Alexander Memorial Prize, consisting of £50 and a gold medal, is awarded every third year to writer of the best essay on a subject connected with military medicine, surgery or hygiene. The subject for the next prize essay is "Tropical Abscess of the Liver." The subject may be treated either from a clinical or an atiological standpoint, and the essay must be revised. must bear evidence of original observations. Further particulars may be obtained on application to the Secretary of the Prizes Committee, Royal Army Medical College.

MESSRS. MACMILLAN AND Co. announce as in course of publication a second edition of "A New System of Medicine," by many writers, edited by Sir Clifford Allbutt, K.C.B., and Dr. Rolleston. Mr. H. K. Lewis announces a "Manual of Operative Surgery," by Dr. John F. Binnie, Professor of Surgery in Kansas Medical College, in two volumes, the first of which—"Operations on the Head, Neck, Nerves, Trunk, Genito-Urinary Organs, etc."—is now ready, and is complete in itself.

Dr. RABAGLIATI, of Bradford, sends us a booklet entitled "Evolution, False and True: A Twentieth Century Message." The tiny venture is in verse—very good verse some of it—a portion being devoted to the nineteenth century and the remainder to the twentieth. In it our confrère endeavours to combat Darwin's theory of the origin of species, and from strong reli-gious conviction relies on "the simple creed that God creates."

We understand that a new and revised edition of Dr. Samuel West's thoughtful work on "Diseases of the Organs of Respiration" is about to be published by Messrs. Chas. Griffin and Co., Limited. The work was so highly appreciated on its first appearance that it was felt a new edition would be called for at no distant date. The author has extended the text and, by careful revision. has brought the book up-to-date.

A FIFTH edition of that classic on "Diseases of the Ear," by Professor Politzer, reached us as we were going "to press." At such short notice we can only announce the fact, merely adding that it has been translated at the author's request, as was the previous edition, by two of his former pupils, Drs. Ballin and Heller, and appears to be more than a revised version, Heller, and appears a re-written book, in fact.

WE are not surprised to see still another edition of Mr. Lockhart Mummery's "The After-Treatment of Operations," announced. This unpretentious yet Operations," eminently practical work attracted immediate attention on its inception, and a second edition was quickly called.

#### NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publica-tion of our last monthly list:—

FELIX ALCAN (Paris).

Le Disbete Sucre. Par R. Lepine. Price Fr. 16.

EDWARD ARROLD (London).

Lectures on Diseases of Children. By Robert Hutchison,

M.D. F.R.C.P. Second Edition, revised and enlarged. Illustrated. Pp. 426. Price 8s. 6d. net.

JOHN BALE, SONS AND DANIELSSON. LTD. (London). Tuberculin in Diagnosis and Treatment. By Dr. Bandelier and Dr. Roepke Translated from the Second German Edition, by Egbert C. Morland, M.B., B.Sc.Lond., M.D.Berne. Pp. 582. Price 7s. 6d. net.

Notes and Thoughts from Practice. By W. J. Tyson, M.D., F.R.C.P., F.R.C.S. Pp. 95. Price 2s. 6d. net.

Rational Immunisation in the Treatment of Pulmonary Tuberculosis and other Diseases. By E. C. Hort, B.A., B.Sc., M.R.C.P. Pp. 75. Price 3s. 6d. net.

Notes on Soured Milk. By Elie Metchnikoff, of the Pasteur Institute, Paris. Pp. 20. Price 1s. net
A History of the Reading Pathological Society. By Jamieson B. Hurry, M.A., M.D. Illustrated Pp. 179. Price 7s. 6d. net.

BAILLIERE, TINDALL AND COX (London).
Operative Nursing and Technique. By Charles P. Childe, B.A., F.R.C.S.Eng. Pp. 224. Price 3s. 6d. net.

Aids to Medicine. By Bernard Hudson, M.D.Cantab., M.R.C.P. Lond. Price, cloth, 3s. net; paper, 2s. 6d. net.

The Nauheim Treatment of Diseases of the Heart and Circulation. By Leslie Thorne Thorne M.D., B.S.Durham, etc., etc.

Aids to Forensic Medicine and Toxicology. By Wm. Murrell, M.D. F.R.C.P. Seventh Edition. Pp. 123. Price, cloth, 2s. 6d. net; Paper, 2s. net.

Lectures to Practising Midwives. By Victoria E. M. Bennett, M.B., B.S.Lood., D.P.H.Cambs. With Preface by Mrs. Mary Scharlieb, M.D., M.S.Lond. Illustrated. Pp. 256. Price 4s. net.

Translated at the personal request of the Author, and Edited by Milton J. Ballin, Ph.D., M.D., and Clarence L. Heller, M.D. New (Fifts) Edition, entirely re-written. Illustrated. Pp. 852. Price 25s. net.

Cassell And Co., LTD. (London).

A Manual of Operative Surgery. By Sir Frederick Treves, Bart., G.C.V.O., C.B., LLD, F.R.C.S., and Jonathan Hutchingon, F.R.C.S. vol. I. Third Edition. Illustrated. Pp. 775. Price 18s. net.

Chuschll, J. and A. (London).

A Manual of Operative Surgery. By Sir Frederick Treves, Bart., G.C.V.O., C.B., LLD, F.R.C.S., and Jonathan Hutchingon, F.R.C.S. vol. Ind. A. (London).

Southall's organic Materia Medic 462 THE MEDICAL PRESS.

Sprains and Allied Injuries of Souther. By M. H. Main. Price 10ckg. M.D., M.C., F.R.C.S. Illustrated. Pp. 241. Price 7s. 6d. net
WILLIAM HODGE AND CO. (Edinburgh).
The Alcohol Case. (The Summing Up.) By Father Power, S.J. Pp. 48. Price 6d. net.
H. K. Lewis (London).
The Operations of Aural Surgery. By C. Ernest West, F.R.C.S., and Sydney R. Scott, M.S., F.R.C.S. Illustrated. Pp. 201. Price 7s. 6d. net.
Manual of Operative Surgery. By John Fairbairn Binnie, A.M., C.M.Aberd. Vol. 1. Fourth Edition, revised, enlarged, and illustrated. Pp. 832. Price 14s net.
E. AND S. Livinostone (Edinburgh).
The Studenta Pocket Prescriber. By H. Aubrey Husband, M.B., C.M., etc., etc. New Edition. Pp 175, Price 1s. 6d. net Longmans, Green and Co. (London).
Lectures on the Use of Massage and Early Movements in Recent Fractures. Sir Wm. H. Bennett, K.C.V.O., F.R.C.S., Fourth Edition. Hustrated. Pp. 134. Price 6s.
MACMILLAN AND CO., LTD. (London).
Home Nursing, with Notes on the Preservation of Health. By Isabel Macdonald. Illustrated. Pp. 326. Price 2s. 6d. net.
Thomas Nelson and Sons (London).
The Children's Charter: A Sketch of the Scope and Main Provisions of the Children Act, 1908. By M. R. Inglis, with a preface by The Rt. Hon. Herbert Samuel, M.P. Pp. 64. Price 6d. net.

James Nieber and Co., Limited (London).
Essays on the Position of Abdominal Hysterectomy in London. By John Bland-Sutton, F.R.C.S.Eng. Pp. 90. Price 2s. 6d. net.
Press of American Medical Association (Chicago).

PRESS OF AMERICAN MEDICAL ASSOCIATION (Chicago).

New and Non-official Remedies, 1909. Pp. 167. Price, paper,

PRESS OF AMERICAN MEDICAL ASSOCIATION (CRICAGO).

New and Non-official Remedies, 1909. Pp. 167. Price, paper, 250.: cloth, 500.

SMITH, ELDER AND CO. (London).

Saint Bartholomew's Hospital Reports. Edited by H. Morley Fletcher, M.D., snd W. McAdam Eccles, M.S., F.R.C.S. Vol. XLIV. Pp. 190. Price 8s. 6d. net.

SPOTTISWOODE AND CO., LIMITED (London).

The Medical Register. 1909. Pp. 1872. Price 10s. 6d.

The Dentists' Register. 1909. Pp. 1872. Price 3s. 4d.

G. STEINHEIL (Paris).

Etudes. Anatomo-Cliniques. Cour-Caisseaux-Poumons, par Le Dr. Raymond Tripier. Pp. 604. Price 10 francs.

JOHN WRIGHT AND BOSS, LID. (Bristol).

The Medical Annual, 1909. Price 8s. 6d. net.

Golden Rules of Amesthesia. By R. J. Probyn-Williams, M.D.

Third Edition, revised. Pp. 67. Price 1s.

Health, Morals, and Longevity. By George Gresswell, M.A.

Oxford and Cape, L.R.C.P., and S.Edin., L.F.P.S.G., and Albert Gresswell, M.A., M.D., Oxford, M.R.C.S., F.R.S.M., Pp. 229. Price 5s. net.

#### MEDICAL NEWS IN BRIEF.

#### Prevention of Ophthalmia.

A CONFERENCE of Medical Officers of Health of the district round Birmingham was held at Hanley on April 29th, to consider the question of the prevention of blindness following infantile ophthalmia. The Mayor of Hanley (Mr. G. F. Adcock) presided, and stated that that was the second meeting held as the outcome of a suggestion made by Dr. Folker at the annual meeting of supporters of the Workshops for the Blind to the effect that possibly a great number of cases of blindness were preventable if dealt with at an early stage, and that at least 40 per cent. of the cases of blindness were attributable to ignorance and neglect at that stage. At the first meeting it thought desirable that ophthalmia neonatorum should be made compulsorily notifiable, and that conference had been convened to further consider the matter with the assistance of the County Medical Officer and the Medical Officers of the district.

Mr. E. V. Greatbatch (Chairman of the Joint School Authority and of the Workshops for the Blind) said that to allow sighted infants to become blind when that to allow signed infants to become blind when that blindness could be prevented was a wasteful, extravagant, costly, and cruel way of dealing with humanity. What was wanted was to get the Local Government Board to make notification of ophthalmia in infants compulsory, so that the cases might be dealt with immediately. Dr. H. H. Folker advocated com-

pulsory notification.
Dr. G. Reid (County Medical Officer) explained the difficulties in the way of action in the matter without an alteration of the law, but suggested that a deputa-tion might be appointed to confer with the President of the Local Government Board.

#### Durham County Sanatorium for Women.

On May 1st there was inaugurated an important phase of the work of the Society for the Prevention and Cure of Consumption in the County of Durhamnamely, the opening of the Sanatorium for Women, which is situated at Wolsingham. The ceremony was performed by the President of the Society. Lord Barnard. The Society was founded in 1898, and the Stanhope Sanatorium was opened in May, 1900. This sanatorium provides accommodation for 31 male and 14 female patients. For some years the committee have felt, in view of the increasingly large number of applications for admission, that it was desirable to acquire another building, retaining the Stanhope Sanatorium for male patients, and devoting the new building to the treatment of women. With this end in view, funds have been accumulated, and the Leazes House, Wolsingham, a beautifully situated mansion standing in 5 acres of grounds, together with an adjoining field of 10 acres, has been purchased by the committee. It is estimated that a sum of £1,000 will be required in order to defray the cost of necessary alterations and furnishing, and it has been suggested that it would be a graceful and most appropriate seracquire another building, retaining the Stanhope Sanathat it would be a graceful and most appropriate service if the ladies of the county would undertake to provide this sum for their suffering sisters.

The new sanatorium at Wolsingham will provide accommodation for 28 women patients, and the committee actions that it like Contests will be considered.

mittee anticipate that it-like Stanhope-will be practically self-supporting by means of patients' contributions, annual grants from local authorities, and workmen's subscriptions.

#### Esperanto in Ireland.

DR. G. JAMESON JOHNSTON has been appointed Consul for Ireland for the Universal Medical Esperanto Association, and also "Deligito" for Dublin for the Universala Esperanto-Asocio. He has already obtained a number of new members for both Associations, and we are asked to point out that anyone interested in the movement can obtain all information by applying to him at his residence. by applying to him at his residence, 13 Lower Fitz-william Street, Dublin. We understand that an attempt is to be made to induce the Royal Colleges to place Esperanto on the list of optional subjects for their preliminary examination.

#### Glanders in London.

TWENTY-Two summonses, II against the London Parcels Delivery Company, Limited, and II against Mr. Clampett, their horse superintendent, were heard on April 29th at Bow Street.

The complaint was that the company, which owns 600 or 700 horses in London, had failed to notify one case of glanders and several of suspected glanders at their stables at Hampstead, Stepney, Eltham, and Fetter Lane.

Counsel stated that the matter was brought to notice by the death of an employee named Davis in February from glanders—a terrible disease, extremely catching, from which victims hardly ever recovered.

The defence was that the company was unaware of the existence of the disease, which was an insidious one, and sometimes existed without external symptoms. Two summonses were withdrawn, and the remainder were adjourned.

#### Royal Institute of Public Health.

A COURSE of lectures on "Army Sanitation" has been arranged for delivery at this Institute on every Wednesday, commencing May 12th till June 16th inclusive, at 6 p.m. each day. The first lecture will be delivered by Surgeon-General G. J. H. Evatt, C.B., M.D., on "The Officer and his Duties towards the Well-being of the Soldier under his Command," followed by "The Practical Sanitation of Camps," by Lieut.-Col. R. H. Firth, F.R.C.S.; "The Essential Principles of Sanitation in the Field," by Lieut.-Col. C. H. Melville, M.D.; "Hospital Work in War," by Lieut.-Col. R. J. S. Simpson, C.M.G., M.B.; "The Bacteriology of Diseases Common to Armies in the Field," by Professor R. Tanner Hewlett, M.D., F.R.C.P.; the final lecture being on "Inoculation Methods for the Prevention of the Diseases to which the Soldier is Liable," by Lieut.-Col. S. Monckton Copeman, M.D., F.R.S.

The Hon. Secretary, Mr. James Cantlie, F.R.C.S., asks us to announce that all officers of the Territorial Force will be cordially welcomed.

#### Bolingbroke Hospital.

The annual general meeting of the Governors of this Institution was recently held at the hospital, Wandsworth Common, Canon Erskine Clarke, Vicar of Battersea, presiding. The chairman said that subscriptions during the year had amounted to only £525, but there had been a considerable income from donations and legacies. Increased subscriptions were urgently needed, since the cost of maintaining the accident branch of the hospital exceeded £2,000 per annum. Dr. Howell, a member of the Wandsworth Borough Council, referred to the Weir bequest, and said it was difficult to understand why the Wandsworth Borough Council opposed its application to the Bolingbroke Hospital. Last year the cases from the borough of Wandsworth outnmbered those from Battersea. The report and financial statement were adopted.

#### The Medical Defence Union.

THE annual general meeting of the Medical Defence Union, Limited, will be held at the Medical Library. University College, Bristol, by the kind permission of the authorities, on Thursday, May 27th, at 4.30 p.m., when the annual report will be presented and the usual statutory business carried out.

#### Che'sea Hospital for Women.

By the kind permission of Mary, Countess of Ilchester, a concert in aid of the Chelsea Hospital for Women will be held in the Garden Ball Room at Holland House, Kensington, on Friday, June 11th, at 3 p.m.

#### Royal College of Physicians of London.

At the meeting of the Council of the College, the L.R.C.P. was conferred upon the following or candidates who had passed the Final Examination in Medicine, Surgery, and Midwifery of the Conjoint Examining Board:

Adolphe Abrahams, B.A.Cantab.; Harold W. L. Allott, Mukhtar Ahmed Ansari, B.A., M.B., Ch.B., Richard R. Armstrong, B.A., Cantab., John Lee Atkinson, Kenneth J. Aveling, Bertram F. Bartlett,

Phirozshah B. Bharucha, L.M., Harold E. Bloxsome, Trevor L. Bomford, William F. Bowen, Harold Bowring, B.A. Cantab, Eldred C. Braithwaite, M.B., B.S. Durham, Thomas F. Brown, William H. Butler, Frederick G. Caley, B.A. Cantab, Frederick G. Cawston, B.A. Cantab, Howard D. Clapham, Alfred J. Clark, B.A., Cantab, John P. Clarke, Kenneth Comyn, Reginald B. Dawson, L.M.S.S.A., Canut Deuntzer, James R. Dick, B.A. Cantab, Josiah R. B. Dobson, Malcolm Donaldson, B.A. Cantab, Archibald W. Duncan, George H. Dunn, M.A. Cantab, Leslie W. Evans, Thomas Evans, Philip C. Field, Howell W. Gabe, Edward B. Garrard, Paul K. Gilroy, B.A. Cantab, Claude Gouldesbrough, M.A. Oxon, George A. Greaves, Harry S. Hall, B.A. Cantab, David J. Harries, B.Sc. Wales, Thomas Harrison, M.B., Ch. B. New Zealand, Henry Hudson, Edward P. L. Hughes, Robert H. Hutchinson, B.A. Cantab, Victor P. Hutchinson, Robert S. Ingersoll, Roger P. Jones, Charles F. V. Kebbell, Latafat Husain Khan, Henry G. Kilner, Septimus J. Lee, Arthur S. MacNalty, Reginald H. Mawhood, B.A. Cantab, James K. Milligan, Howard E. H. Mitchell, Edwin B. Morley, Harold R. Moxon, Naranji Ranchhodji Naik, Frederick C. Nichols, L.D.S. Eng., Ralph Daniel O'Leary, M.B., Ch.B. Melbourne, Douglas G. S. R. Oxley, George F. Page, Robin Pearse, Lionel B. Perry, Roger A. Rankine, Alexander A. Rees, M.B., Ch.B. Liverpool, Edward D. W. Reid, B.A. Cantab, Arthur Rhodes, Arthur D. Rope, Frank A. Roper, B.B. Cantab., Arthur J. Ryle, M.B., Ch.B. Edin., Frederick F. Saldanha, L.M. and S. Bombay, Norman G. H. Salmon, August C. Schulenburg, M.D. Washington, Charles F. Searle, B.A. Cantab, Norman S. Shenstone, B.A., L.M.S.A., M.D. Columbia, Samuel Shepheard, Henry G. Smith, Reginald R. Smith, Ernest R. Stone, B.A. Cantab, Thomas W. R. Strode, William F. Sutcliffe, Harold L. Tasker, Henry A. Treadgold, B.A. Cantab, Rupert J. Vernon, B.A. Cantab, Donald Wainwright, Henry C. Waldo, Gordon R. Ward, Leonard M. Webber, Mathias W. E. Widegren, Walter G. Wince, L.M. and S. Calcutta, Robert N. Woodsend, and Thom

# Royal College of Physicians and Surgeons, Edinburgh, and Faculty of Physicians and Surgeons. Glasgow.—Triple Qualification, R.C.P.E., R.C.S.E., P.P.S.G.

At the April examinations of the above Colleges, held in Glasgow, the following passed the First Professional Examination:—Henry Shaw, Alexander M. Robertson, William Laird, Michael M'Closkey, and James J. Kelly.

The following passed the Second Professional

The following passed the Second Professional Examination:—William Millerick, Cyril S. Owen, Arthur L. Edwards, James Macrae, James A. Hutchinson, Furdon F. Keravalla, Henry R. Macnab, Colin Hunter, and Amabile Caruana.

The following passed the Third Professional Examination:—Hugh F. Williams, James Blackburn, Patrick Walsh, Cornelius A. O'Driscoll, John W. Robertson, Dinshaw Bhicaji Gazdar, William Browne, Erach D. Shroff, Francis P. Quirk, Nariman Byramji Mehta, William M. Thomson, Ralph C. Fuller, and Seringapatam N. S. Aizangar.

The following passed the Final Examination, and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P.S.G.:—David George Lindsay, Glasgow; Nariman Byramji Mehta, Bombay; John M'Call, Tasmania; Vaman Gopal Gokhale, Kolhapur, India; Henry Eric Swan, Ceylon, and Isabel Pulteney, Ashley, Northants.

THE Royal College of Physicians of London has enacted the following by-law relating to the admission of women to examination for the college diplomas:—
"Women shall be eligible for admission as licentiates and members of the college and for a grant of a diploma in public health on the same terms and conditions as men; and so far as is necessary to give effect to this by-law, words in the by-laws and regulations importing the masculine gender shall include females, and all proper alterations shall be made in the forms of the letters testimonial, and the licence granted by the College.

#### **NOTICES TO** CORRESPONDENTS.

CORRESPONDENTS requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

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MRS. EDWIN B. (London).—Every year a certain number of London working boys are sent away to seaside camps by an association organised for that purpose. Each boy has to pay a certain sum towards maintenance. Particulars can be obtained of the Secretary, Mr. F. A. Bloxbam, 23 Northumberland Avenue, London, W.C.

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London, W.C.

Pendragon (Somerset).—Many medical men have been well-known figures in the hunting field, as, indeed, they have at one time or another in almost all forms of British sport. It is impossible to give any exact estimate, but many a man of good constitution is able to hunt comfortably up to seventy, or even eighty vears of age. Fatalities in the hunting field are inseparable from the pursuit. Happily, however, in many severe injuries to the spinal column the resources of modern surgery are able to save life, and even to restore, more or less, completely to health.

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A. D.

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#### Meetings of the Societies, Tectures, &c.

WEDNESDAY, MAY 5TH.

WEDNESDAY, MAY 5TH.

MEDICAL GRADUATES' COLLEGE AND POLICLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Cantile: Clinique (Surgical), 5.15 p.m.: Lecture: Mr. Bland-Sutton: The Baneful Effects of Pregnancy on Uterine Fibroids.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Weles's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whiphaim); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

Thursday, May 6th.

Ophthalmological Society of the United Kingdom (11 Chandos Street, Cavendiah Square, W.).—3 p.m.: Card Specimens will be shown by Major R. H. Elliott, I.M S., Mr. S. Stephenson, Mr. G. W. Roll, and others. 8.30 p.m.: Pr. G. Carpenter: A Short Note on Tubercle of the Choroid with an Account of a Recent Case. Mr. M. Davidson and Mr. A. Lawson: A Case of Spring Catarrh Treated and Cured by Radium. Mr. R. R. Cruise: The Abuse of Atropin in Refraction Work. Mr. S. Mayou: On, the Disappearance of the Iris from the Papillary Area following Injury. Mr. W. H. H. Jessop: The Report of the International Committee on the Unification of the Notation of Visual Acuity and of the Meridians of Astigmatism.

Norh-East London Clinical Society (Prince of Wales's Hospital, Tottenham, N.).—4.15 p.m.: Clinical Cases.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chemies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture: Dr. G. H. Savage: The Feeble minded and their Care.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynscological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Bays. 5 p.m.: Medical In-patient (Dr. G. P. Chappel).

ROYAL SOCIETY OF MEDICINE (LAENNOOLOGICAL SECTION) (20, Hanover Square, W.).—5 p.m.: Dr. Dundas Grant: Two Cases. Dr. Donelan: (1) Laryngeal Tuberculosis in a Man, aged 43; (2) Deflection of Septum in a Boy, aged 13: Question of Resection; (3) Recurrent Occlusion of Naris. Mr. Herbert Tilley: Chronic Suppuration in the Left Sphenoidal Sinus; Recovery Dr. Jobson Horne: Fination of Right Vocal Cord, of Intermittent Occurrence. in a Man aged 40. And other Cases.

ROYAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Field: W.C.).—5 p.m.: Prof. Keith: On Specimens illustrating Malformations of the Nock. (Museum Demonstration.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. S. Stephenson: Clinique (Eye).

CENTRAL LONDON THROAT AND EAR HOSFITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. A. Wylie: Larynx.

ROYAL SOCIETT OF MEDICINE (OTOLOGICAL SECTION) (20, Hanover Square, W).—10 a.m.: Cases and Specimens: Mr. C. C. West: Further notes on Case of Caronoms of the Ear. Dr. Adolph Bronner: Cholesteatoms of the Ear treated with Ensymol. Mr. R. Lake: Case of Epileptiform Attacks of Labyrinthine Origin, and Other Cases. Mr. Hunter Tod and Mr. A. L. Whitehead will also show Cases and Specimens.

## Appointments.

DE SOUZA, D. H., M.D., M.R.C.S., L.R.C.P., House Physician to University College Hospital.

FERNIE, F. E., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Stone District

under the Factory and Workshop Act for the Stone District of Stafford.

Hancock, W. Ilbert, F.R.C.S.Eng., Assistant Surgeon to the Royal London Ophthalmic Hospital (Moorfields).

Hogarth, Robert George, F.R.C.S.Eng., one of the Medical Referees under the Workmen's Compensation Act, 1906, for County Court Circuit No. 18, and to be attached more particularly to Nottingham, Newark, and Bingham County Courts.

Kauffmann, Otto Jackson, M.D.Lond., one of the Medical Referees under the Workmen's Compensation Act, 1906, for County Court Circuit No. 26.

Maitland, Latton Pelham, M.B., B.S.Lond., Medical Registrar to Charing Cross Hospital.

#### Vacancies.

Middlesex County Asylum, Napsbury, near St. Albans.—Fourth Assistant Medical Officer. Salary, £160 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent. Victoria Hospital, Folkestone.—House Surgeon. Salary, £100 per annum, with board, residence, and laundry. Applications to the Scoretary.

Applications to the Medical Superintendent.

Victoris Hospital, Polkestone.—House Surgeon. Salary, £100 per annum with board, residence, and laundry. Applications to the Secretary.

Royal South Hants and Southampton Hospital.—House Physicias. Salary, £100 per annum with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Newcastle-upon-Tyne Crit Lunatic Asylum, Gosforth, Newcastle-upon-Tyne.—Second Assistant Medical Officer. Salary, £140 a year, with furnished apartments, board, and laundry. Applications to Dr. Callcott, Medical Superintendent.

Stockton and Thornaby Hospital, Stockton-on-Tees.—House Surgeon. Salary, £160 per annum, with residence, board, and washing. Applications to H. G. Sanderson, Secretary, 63 High Street; Stockton-on-Tees.

Suffolk District Asylum, Melton.—Second Assistant Medical Officer. Salary, £160 per annum, with board, furnished apartments, attendance, and laundry. Applications to the Medical Superintendent.

The Hospital for Sick Children, Great Ormond Street, London. W.O.—House Surgeon. Salary, six months, £30, washing allowance £2 10s., and board and residence in the Hospital. Applications to the Secretary. (See advt.)

#### Births.

CARTER.—On April 29th, at 4 Edgar Buildings, Bath, the wife of Stuart Uarter, L.D.S., R.O.S.Eng., a son.
KEMPTHORNE.—On April 25th, at Mussoorie, India, the wife of Capt. G. A. Kempthorne, R.A.M.O., of a daughter.

#### Marriages.

ROE-WALKER.—On April 29th, at S. Luke's, Nightingale Lanc. London, Rev. Everard V. Roe, B.A., R.N., fourth son of Edwin H Roe, M.R.O.S., and Mary Edith Dorothea, second daughter of the late Edward Walker, M.A., Barrister-at-Law.

#### Deaths.

MALLARD.—On April 27th, at Holly Cottage, Pine Bidge, Farnham Kate, the wife of F. B. Mallard, M.B.C.S.Eug., of Hammersmith.





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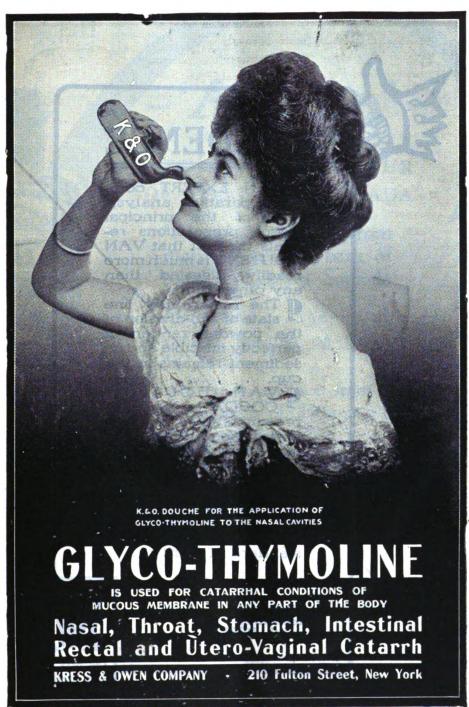
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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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#### Notes and Comments.

An interesting variation from the A Strike usual run of strikes is reported to be of taking place in the village of Saint-Patients. Sauveur, Canton de l'Yonne. The district, it seems, is served by two medical practitioners who have recently agreed with each other to raise their fees to the extent of a third. Knowing what most medical fees on the Continent amount to, we cannot think that when enhanced by 33 per cent. they would be very ruinous, but Saint-Sauveur, having always enjoyed the privilege of cheap medical attendance, is aghast at being called upon to pay more than the modest sums usually demanded of it. The neighbours, therefore, have met and informed the doctors that they will stand no advance in prices, and that in future they decline to be attended by such avaricious

gentlemen. In the meantime, they are trying to do without medical attendance, and to import a "blackleg" who will carry on practice at the old rate. Undeterred by the prospect, the doctors have decided on a "lock-out," and matters seem to have wallowed to an impasse. Although we are not in a position to judge of the capabilities of the inhabitants of Saint-Sauveur to pay more than they have been doing for medical attendance, we gather from much that has taken place in this island that the doctors have probably been imposed upon whole-sale, and our sympathies would therefore naturally be with them. This form of strike is a novel one, and its issue will be a matter of no little importance, on the question of principle alone.

Steamboats on

From the public health point of view it is highly regrettable that the London County Council persist in the Thames. refusing to run a summer service of steamboats on the Thames. It is

difficult to steer clear of the whirlpool of municipal politics in speaking of this matter, as it has divided the Council on the exact line of party cleavage. That this should be so is much to be deprecated. When the steamboat service was started three years ago, a new means of pleasure and recreation was afforded to the toiling millions on the banks of the river from Battersea to Greenwich. The popular fares and the comfortable boats tempted thousands of the poor from their stuffy homes in courts and alleys on Saturday and Sunday afternoons in the summer, and the gain to their health was no whit less than that provided by an afternoon in the parks or the country. The argument that the service did not pay deserves careful consideration, and we are not prepared to deny that the administration was not over-sanguine in its calculations. With the experience now gained it ought to be possible to put on a limited service which would pay its way, and even if there were a deficit, it has to be remembered that large sums are still annually payable for interest and sinking fund for the service of the debt incurred in initiating the service. Because the steamers are not running it does not mean that expenses thereby cease. Moreover, in matters of public health we have never yet heard it asserted that pure commercial considerations alone should count, as apart from sewerage, asylums, and similar heavy items of expenditure, the cost of the public parks is very large, and begrudged, as far as we know, by nobody. It is pitiable that these fine steamers which are capable of giving so much health and pleasure to thousands should be sold out of the country for a mere song.

MR. LUPTON tried to "draw" Mr. Vaccination Burns last week on the subject of and the Bristol vaccination, and, boomerang-like, Outbreak. the effort recoiled, to his extreme

discomfiture. The interrogation he put to the President of the Local Government Board was whether, during the recent outbreak at Bristol, small-pox had shown any partiality for unvaccinated children. Now Mr. Lupton knew the numbers attacked had been very small, and in a fairly well-vaccinated community like Bristol the great probabilities were that the number of children under fourteen who were attacked would have been the elder vaccinated ones, in whom the effect of the inoculation was beginning to wear off. As it happened, however, Mr. Burns was able to tell the same tale of the little Bristol outbreak as has been told by every epidemic since vaccination was introduced, namely, that of high incidence and fatality in unvaccinated children, and low incidence and mild invasion in the vaccinated. The actual figures were, for children under fourteen, two abortive attacks in the vaccinated, and seven confluent attacks with three deaths among the unvaccinated. It is lamentable to think of these little ones' lives being sacrificed and the survivors scarred for life owing to the ignorance and prejudice of the antivaccination fanatics, and we only hope that when Mr. Burns gives up the reins at the Local Government Board he will be definitely convinced from his tenure of office that the immunity against small-pox conferred by vaccination is one of the greatest social benefits that medical science has yet been able to put forward.

and Drug Preparations.

THE extraordinary ramifications of The Budget modern commerce often direct the incidence of a new tax into most unexpected directions. In the case of the additional 3s. 9d. per gallon

duty on proof spirit a vast amount of inconvenience and increased expenditure will be thrown upon the shoulders of consumers. Those who are conversant

with the practical side of dispensing know that one of the most expensive items in the wholesale chemist's bill is that of the tinctures. On the principle that consumers have to pay much more than the increased cost of a supertax, the future price of medicines prepared wholly or partially by the aid of spirit will be considerably enhanced. On the other hand, it is well known that excellent and wholly satisfactory substitutes may be obtained in the shape of infusions and decoctions, or of solutions of active principles, not to mention other ways of avoiding the use of spirit. This move should please the teetotalers, who have for a long time past inveighed against alcohol in the medicine bottle. It is indeed an ill wind that blows no one good!

#### LEADING ARTICLES.

MIDWIVES AND DEATH CERTIFICATES.

THE relations between the public and the medical profession on the one hand, with the certificated midwives on the other, are at the present moment to a great extent being subjected to the investigation of a Departmental Committee. In the meantime what the local press describes as "extraordinary revelations" has taken place in a Cornish village, where two infants were buried on the strength of a document signed by a certificated midwife and handed to a gravedigger. The whole case was investigated at length by Mr. Edward Boase, the Coroner for the district, and it appears to be of such importance that no apology is needed for bringing it prominently before the attention of medical readers. Briefly stated, the facts, as elicited at an inquest held on April 20th, and reported in the Cornishman of May 1st, are that twin children—a boy and a girl—were born on April 10th at Ludgvan. The mother, the wife of a miner, was attended at her confinement by a certificated midwife, named Mary Ann Bennetts. The female child died two days after birth and was buried in the cemetery on the 12th by Henry Thomas, gravedigger, at the request of the father, there being no written authority for the burial from anybody. On this point the gravedigger stated in evidence that the father told him the child had lived a little while, but Mrs. Bennetts would furnish him with a line that would clear him. He buried the child, but was unable to get the certificate or document from the midwife because she had gone away. The other child died on April 17th and was buried on the 19th. The gravedigger said that on being asked to bury the second child, he referred the father to Mr. Rowe, the local surveyor, who had charge of the cemetery. Ultimately he buried the boy, apparently trusting to the authorisation of a certificate to be obtained from the midwife, Mrs. Bennetts, on her return. This witness appeared to be devoid of the most elementary knowledge as to his duties and responsibilities in the matter of burial. He admitted that he had buried children up to the age of six weeks on the authority of the midwife, and then remarked that "they have been still-born." These hazy notions as to the definition of "still-birth" appear to have been shared by the surveyor, Rowe, who is reported to have said he would receive a certificate from a nurse up to a week old, a period which was extended in a subsequent answer to three weeks. The surveyor said he was given to understand the girl was still-born, and he consented to the burial of the boy because he thought they would be furnished with a certificate from the nurse. The fact of the burials came to the knowledge of the local registrar, Mr. Sandoe, with whom no intimation of either the births or the deaths of the children had been lodged. A certificate was then forthcoming from the midwife, as follows:—

"Crowlas, Ludgvan.

"I, Mary Ann Bennetts, holding a certificate from the Central Midwives Board, pursuing my calling at Crowlas, Ludgvan, do hereby certify that the children of James and Beatrice Boase, of Canonstown, born April 10th, have since died owing to premature birth (time about seven months). My last visit was April 18th, 1909.—Signed, Mary Ann Bennetts, certificated midwife."

This document, it will be seen, was not dated, and, although it gave the day of birth, gave no date of death. It was, in a word, of an irregular and insufficient nature. The Coroner ordered a post-mortem examination, and the medical evidence showed healthy organs in both children-each weighing 4lbs.—with absence of food in the stomachs. In the opinion of the medical witness, death was due to congenital weakness and want of attention. The verdict returned by the jury was that the children died of congenital weakness and neglect, but not criminal neglect. They added as rider, that in their opinion Mrs. Bennetts was not fit to hold a certificate as a midwife, and that the Ludgvan Urban Council should make regulations for the control of their cemetery. The attitude taken up by the jury does not err on the side of severity. A certificated midwife who fails to call in medical advice to children in an obviously precarious condition, and who grants certificates such as that above quoted, and who admits she has never read her regulations, need not be surprised if she finds herself involved in circumstances that will deprive her of a certificate or result in even more serious consequences. Nor is the position of officials responsible for the discharge of so serious a public duty as the burial of the dead any more enviable, if they be shown to lack rudimentary information as to the legal qualifications and restrictions of his office. But the urban authorities who employed the gravedigger and the surveyor must be asked to explain their position in the affair, and to account for the absence of clear and definite rules in the conduct of a public burial ground administered under Acts of Parliament. There can be little doubt that in the past considerable laxity has prevailed in the matter of the burial of still-born infants and of those who have died soon after birth, and it may be hoped that the Ludgvan incident may not escape the attention of the Home Office and of all who are interested in the working of the Midwives Act.

## THE POOR-LAW COMMISSION AND IRELAND.

It is now about two years and a half since a Viceregal Commission, appointed to consider the question of Poor-law reform in Ireland, presented a far-reaching report which obtained an unusual degree of public support. Naturally there were

differences as regards details, but, on the whole, there was a general wish that legislation should speedily take place on the lines of the suggestions of the Commissioners. As, however, a Royal Commission was in session at the same time, whose function was to report on English and Irish Poor-law, the Government naturally refused to move until its Report also was presented. The circumstances were somewhat unfortunate for those interested in Irish Poor-law questions. On the one hand was a small Commission of three, all men intimately acquainted with Ireland and its problems, whose business was to deal with an Irish problem alone and without reference to any extraneous circumstances. On the other hand was a large Commission of eighteen, only two of whom could have any practical experience of Irish affairs. It was a Commission whose main business and interests were with English affairs, to whom the Irish problem was merely a branch of the English, and not an independent question. It will be seen, therefore, that it was hardly to be expected that a practical solution should be reached by two such bodies approaching it from different points of view, with different interests, and independently of each The result is, we fear, to postpone the The Royal Commissettlement of the question. sion is divided against itself, and while both the majority and the minority express general approval of the suggestions of the Viceregal Commission, both differ from it so widely as to render it difficult to find even the outlines of a scheme on which all could be agreed. We are at present mainly concerned with Poor-law reform in its medical aspects, and we must confess we have a decided preference for the suggestions of the Viceregal Commission over those of the majority of the Royal Commission. The Viceregal Commission recommended the entire separation from the Poor-law of the treatment of the sick, and the establishment of a State or national medical service. The Royal Commission deal with the treatment of the sick and the entire public health work of the country as part of the problem of poverty, and suggest the establishment of county medical services. Moreover, the suggestion is made that the areas of dispensary districts should, "where possible, be enlarged in view of present population." The problem of dealing with the sick poor in Ireland is, as everyone who knows the country is aware, one not so much of population as of distance. The Report fails entirely to deal with the problem of public health-one of the most pressing in the country. In short, it exhibits all the shortcomings and failings natural, indeed, almost inevitable, considering its origin. Poor-law reform in Ireland is not the same problem as in England any more now than it was seventy years ago. Each problem must be faced separately and independently. The attempt to deal with the Irish problem as a mere incident of the English can only result in failure. The Report of the Royal Commission renders the solution more difficult, in so far as it offers alternatives to the suggestions of the Viceregal Commission. The differences between the two Commissions will inevitably have the effect of making Government shy of proposing any scheme of reform.

#### CURRENT, TOPICS.

"World League" Congress.

THE fourth Triennial International Congress of the World League for the Protection of Animals and Against Vivisection is to be held in London in July, and a programme of the fare with which the gathering of the good delegates is to be provided lies before us. The President of the League is a Serene Highness, but the Vice-Presidents, though they range from Mr. Jerome K. Jerome to Mr. O'Grady, M.P., do not conjure up a title between them. This deficiency, however, is to some extent compensated for by the names appearing in the list of Vice-Presidents of the Congress, which includes the most weird assortment of aristocrats it has ever been our good fortune to read. The league has ideas of entertaining its guests which strike us as not a little odd, for at the preliminary reception the programme includes, besides music, a recitation of "Extracts from a French Play on Vivisection." If this is the most delightful form of amusement that the League can conceive, we feel our humanitarian sympathies are greatly out of touch with theirs, for we see nothing in the sacrifice of animals for the good of man that can, to a healthy mind, make the subject of a French or other kind of "play." Certain items on the programme with regard to cruelty to pit ponies, cruel traps, and so on, we are cordially in agreement with, but the bulk of the bill of fare is concerned with vivisection. General Phelps is to be congratulated on his success in dragging in his favourite subject, for he is announced to read a paper on "Connection between Vaccination and Vivisection," which seems about as ingenious a manner of getting in a hobby as if, say, Mr. Churchill were to lecture on the "Connection between Tariff Reform and Vivisection," or Mr. Bonar Law to speak on the "Relationship of Free Trade to Vivisection." However, we hardly imagine the Congress will take itself very seriously, and its vapourings are not likely to be less futile than those of its class. It is noteworthy that Mr. Coleridge and his Society appear to be eschewing the entertainment altogether.

## A Quarter of a Century's Progress in Public Health.

THE recent presentation to Dr. E. W. Hope, on the occasion of the completion of twenty-five years' service as Medical Officer of Health of Liverpool, gave rise to an interesting review of what had been achieved in public health during that period. Within the first six months of his appointment he certified more than a thousand typhus patients, but to-day that disease is almost unknown. Twentyfive years ago there was no municipal hospital, and the city had to depend entirely on the boards of guardians. Even when the infectious hospital was built it was difficult to get people to come into it-a great contrast from the present state of affairs. Notification has come on the scene, and the sanitary staff has been increased to an adequate strength by a series of Acts of Parliament, some of which originated in Liverpool. The sanitary work of the port, through which as many as 400,000 emigrants passed in a single year, and the enormous importation of foodstuffs, have led to enlarged work for

inspectors; while the task of caring for the health of the children in the schools is only just beginning, and the notification of births may lead to still more duties being cast on the health office. There is, however, one great fact to be proud of and to be seen-the remarkably-improved health of Liverpool. The improvement has taken place not only in the old parish and parliamentary borough of Liverpool, but in all the districts which had been absorbed in the municipal area. The Town Planning Act, which by the provision of wide streets and open spaces is to prevent a repetition of the errors of the past, will result in a further great development of sanitation. Moreover, people were increasingly willing to listen to advice concerning their health and that of their homes, and Dr. Hope can say that poor people are as amenable and as willing and anxious to do what they can for themselves, in a sanitary sense, as any other class. It is reasuring to find that Dr. Hope is full of confidence as to the future progress of public health.

A New Strophanthus.

A GOOD deal of interest is attached to a recent joint communication to the Royal Society of Edinburgh by Professor Sir Thomas Fraser and Mr. Alister P. MacKenzie, a Carnegie research student. Years ago the scientific examination of the arrow poison used by certain tribes of Central Africa resulted in the addition to our pharmacopæia of a most valuable heart tonic derived from strophanthus The original information and the hispidus. materials for investigation were derived from the officers of the Colonial Medical Service. There are many varieties of strophanthus ranging over a large part of West Africa-Gambia, Senegambia, Senegal, and especially in Nigeria. The new variety. the properties of which have been examined by the two authorities mentioned, is the strophanthus sarmentosus, and it is reported to have an action upon the heart closely resembling that of the strophanthus hispidus. The strophanthus sarmentosus is a creeper or vine. The seeds obtained from it are small and attractive, and in a good light exhibit a distinct velvety appearance, which distinguishes them from the seeds of all other strophanthus hitherto examined by Sir Thomas Fraser. The investigation of the new variety leads the authors to the conclusion that strophanthus sarmentosus may possibly become a remedy of much importance and value. Speaking generally, it is of interest to note the wide range of modern scientific medicine, which can extract powerful remedial drugs from so remote and apparently unpromising a source as the arrow poison of savage African tribes.

The Budget.

LAST week we referred to one point in the Budget which affects medical men-the new tax on petrol. There are some others, however, which are also of special interest to us. The first of these is the proposed licence duty on motor-cars, a duty to range from two guineas to forty-two pounds. In the case of this tax, Mr. Lloyd George proposes an exemption of half in the case of medical men. The increased tax of eightpence a pound on tobacco will, of course, tell on medical men as smokers. A considerable inconvenience to the drug trade is the additional

duty of 3s. 9d. a gallon on proof spirit, which will render it difficult for many existing contracts to be carried out. As regards income-tax, there is not much change of a nature to affect the average medical man. On earned incomes up to £2,000 a year the tax remains at ninepence, whereas on unearned incomes the tax has been raised to 1s. 2d. The abatements and allowances remain as heretofore, with the exception of a special abatement for children. In the case of persons whose total income does not exceed £500, an allowance of £10 from the assessment is to be allowed for every child under sixteen years of age. The supertax of sixpence on incomes above £5,000 will affect, we fear, but few members of the medical profession.

#### The Taxation of Motor-Cars of Medical Men.

As we anticipated in a note which we published last week under the above heading, the Chancellor of the Exchequer has intimated that medical men will not be entitled to the rebate in the duty on petrol which is granted to "commercial" users. It is thus obvious that while, on the one hand, a medical man is to be mulcted by the National Telephone Company because he is a "commercial" user of the telephone, he is also to be mulcted by the Chancellor of the Exchequer because he is not a "commercial" user of petrol. In other words, while he has to pay an additional rental for the telephone by means of which he is summoned to his patient because he uses it for business purposes, he is also to pay an additional price for the petrol by the agency of which he arrives at his patient's house because he does not use it for business purposes! Could the desire "to have it both ways' be more clearly shown. Presumably, if Mr. Lloyd George is taxed with the incongruity of his decision, he will answer that the Telephone Company is not a Government department. As it will become one in a very short time, it will be interesting to note how the Government will then regard the medical man. Will he be a commercial or a private user? In the meantime, however, we trust that medical men, both inside and outside Parliament, will try to focus the attention of Mr. Lloyd George on the gross unfairness of penalising medical men, first because they are, and secondly because they are not, business men.

Disease and History.
A FORTNIGHT ago we discussed, briefly, theinteresting theory propounded by Mr. W. H. S. Jones and Dr. Withington as to the relationship of malaria to Greek history and the Greek national character, and though we felt ourselves incompetent to decide as to the weight to be given to the actual evidence in its favour, we expressed ourselves as much interested in this new incursion of biology into the domain of history, and said that we feared it would be resented by the professional This is exactly what seems to have historian. happened, for Mr. Jones's book received a rather short review, considering its importance, in the literary supplement of The Times, and the reviewer evidently was by no means impressed with the strange doctrine. Mr. Jones wrote a carefullyargued letter in reply, but it was not inserted, and

he feels that he has been misunderstood and rather hardly done by. With this view we agree. If we look back upon the effect of plague and small-poxto mention only two prominent maladies—on the course of English history, we can realise to a slight extent what an important factor disease has been in retarding the development of people, while the effect that epidemics have had on the course of warfare might be illustrated by a hundred examples. The general advance of civilisation in the last halfcentury, since attention was paid to sanitation, has been enormous, and if tuberculosis can be eradicated in this country, there is no saying what influence may not be exerted on the race. malaria has played a big part in Greek history no one can doubt, and whether Mr. Jones be right or wrong as to the extent of the rôle he assigns to it, the matter is one which deserves the fullest ventilation.

#### Sentence for Infanticide.

LAST session the Government sustained a defeat in the House of Lords when the Lord Chancellor brought in a one-clause Bill to abrogate capital punishment being inflicted on women who killed The crime of infanticide is an their infants. The crime of infanticide is an awful one, if only for its unnaturalness, but it seems that public opinion has so far condoned it that no murderess of the class has been executed for sixty years. In these circumstances the pronouncement of the death sentence becomes a solemn farce, and we can hardly imagine anyone wishing to perpetuate such a derogation of the dignity of the Court. Last week, Lord Alverstone, as if to atone for his previous opposition to the Lord Chancellor, has brought in a Bill to enable a judge in such cases merely to record the sentence without actually pronouncing it, and this Bill passed its second reading by a large majority. small step in the right direction (though it fits very oddly into the rest of our judicial system) if the farce is to be perpetuated. We regret, for our own part that, if the death penalty is retained in our law and practice, it should be systematically withheld in cases of infanticide. With full sympathy with the seduced and deserted women, we consider that the crime, deliberately perpetrated by women who are not actuated by the impulse of shame and despair, should rank in the gravest category of murder.

#### PERSONAL.

THE EMPEROR OF AUSTRIA has conferred on Dr. Carl Harrer, Physician to the Austro-Hungarian Embassy in London, the Knighthood of the Distinguished Order of the Iron Crown of Austria.

THE Annual Dinner of the Royal Sanitary Institute was held on May 11th at the Langham Hotel, the Chair being taken by the Duke of Northumberland, the President of the Institute.

Dr. J. Lucas-Championniere, President of the International Society of Surgery, is to give the Annual Address to the Cardiff Medical Society on Friday, June 4th. His subject will be "Modern Treatment of Fractures."

THE fifth International Congress of Dental Surgery will be held at Berlin from August 23rd to 28th. The

General Secretary is Dr. Schaeffer-Stuckert, of Frankfort-on-Main. In connection with the Congress there will be an exhibition.

A FESTIVAL banquet in aid of the Mount Vernon Hospital for Consumption will be held at the Hotel Cecil to-morrow. Viscount Clifden, Deputy-Chairman of the Committee, will preside.

THE AMERICAN AMBASSADOR will preside at a Festival Dinner to be held at the Hotel Cecil on Wednesday, June 9th, in aid of the London Fever Hospital, Liverpool Road, N.

THE Annual Meeting of the Invalid Children's Aid Association will be held by permission of Lord and Lady Newlands at 16 Grosvenor Place, S.W., on Tuesday, May 25th. Field-Marshal Lord Grenfell will preside, and the Bishop of Stepney and Sir Alfred Fripp, F.R.C.S., have promised to speak.

HIS EXCELLENCY THE FRENCH AMBASSADOR, supported by the Right Hon. the Lord Mayor and the Sheriffs of London, will preside at the forty-first anniversary dinner for the benefit of the French Hospital and Dispensary to be held at the Hotel Cecil (Victoria Hall) on Saturday next, May 15th.

A SPECIAL meeting of the Dermatological Section of the Royal Society of Medicine will be held on Thursday, May 20th, at 5 p.m., when Dr. Louis Wickham, of the Radium Institute, Paris, will give a lecture and demonstration on "The Therapeutics of Radium."

.THE Annual General Meeting of the Medical Defence Union will be held at the Medical Library of University College, Bristol, on Thursday, May 27th, at 4.30 p.m., when the Annual Report will be presented and the usual business transacted.

Dr. George Charles Barnes, of Liverpool, has been appointed School Medical Officer for the township of Southport, in succession to the late Dr. Hodgson.

The Ingleby Lecture for 1909 in the University of Birmingham will be given on Thursday, May 27th, at 4 p.m., in the Medical Lecture Theatre, by Sir Thomas Barlow, Bt., K.C.V.O., M.D., F.R.C.P. The subject will be "Raynaud's Disease and Erythromelalgia: A Summary and a Review."

The remaining two lectures of the course upon "The Essentials of Physiological History" will be delivered by Dr. David Fraser Harris, M.D.Glas., B.Sc.Lond., F.R.S.E., during the present Summer Session in the Medical Theatre, University of Birmingham. They take place at 4 p.m., and are on the following dates:—May 13th, "The History of Knowledge of the Respiration"; May 20th, "The History of Knowledge of the Nervous System."

THE fourth International Milk Trade Congress will be held, under the patronage of His Royal Highness the Grand Duke Joseph, at Budapest, from the 6th to the 11th of June, this year. It is announced that some 600 persons will take part in the Congress.

THE Sanitary Committee of the Manchester Corporation have appointed Dr. Miles Bracewell Arnold, Assistant Medical Officer of Health for Blackburn, to be Medical Superintendent of Monsall Hospital, in succession to Dr. Gordon, who has resigned. Dr. Arnold was formerly First Assistant Medical Officer at Monsall Hospital for two years.

DR. CHARLES PORTER, Medical Officer of Health of Finsbury, has succeeded Dr. Meredith Young as Medical Officer to the Marylebone Borough Council at a salary of £600 per annum. Dr. Meredith Young has accepted the Medical Officership of Health for the County of Cheshire.

### A CLINICAL LECTURE

ON

#### ALCOHOLIC INSANITY.

By J. O'CONOR DONELAN, L.R.C.P.L, L.R.C.S.I.,

Resident Medical Superintendent to the Richmond District Asylum.

In to-day's lecture I intend to deal with that most important section of mental disease which is due to, or aggravated by, indulgence in alcohol. About 10 per cent. of the cases admitted to our asylums are directly caused by intemperance, while fully 15 per cent. more, though originated by some other causes, are aggravated by it. As in some of the cases of melancholia and paranoia you have seen, the patients suffering from various ill-defined, unpleasant sensations in the early stages of their disease, vainly sought relief in delusive stimulants. At first probably a sense of gratification may have been experienced, but very soon the debili-tating effects of the alcohol crushed out the resisting power of the system, leaving the mind an easy prey to the ravages of hallucinations, delusions, and general decay. No doubt many mild cases of insanity would never develop sufficiently to require asylum treatment if they could have been prevented from trying to "cure themselves," or "cheer themselves," as they express it, in the early stages of the disease.

The type of insanity resulting from alcoholism is by no means constant. Impulsiveness, exaltation, depression, stupor, etc., may be the characteristics of different cases, while epilepsy is often seen for the first time under its influence. It would seem, indeed, that whatever individual predisposition there may be to mental derangement, it is developed under the alcoholic

That hereditary tendency plays an important part in reproducing intemperance and insanity in families is generally admitted, notwithstanding the theory that acquired traits are not transmitted. On looking through our asylum records it is remarkable how often we see evidence of neurotic inheritance amongst our alcoholic cases, and also the frequency of alcoholism in the family history of our feeble-minded and insane patients, who never indulged themselves in alcohol. A kind of mutual dependence seems to exist between alcoholism and insanity, each helping the other in a vicious circle, and it may be to the advantage of our race that they lead to physical degeneration and decay -probably one of Nature's methods of getting rid of the effete.

Alcoholic insanity is classified thus:—(1) Dipsomania; (2) Acute Alcoholism (Drunkenness); (3) Delirium Tremens; (4) Mania-a-Potu; (5) Chronic

Alcoholic Insanity.

Dipsomania is a form of obsessional insanity in which the imperative idea seems to compel its victim, often against his reason and natural inclination, to

break out into alcoholic excess.

J. F. is a remarkable case of this kind. Up to 30 years of age, temperate and industrious, held a firstclass position in a large commercial establishment. He was found in his office in a profound state of intoxication. He was taken home, where he continued drinking, quite regardless of consequences, for some days, when he became violent, delusional, and afflicted by hallucinations of sight, hearing, and taste, and was then committed to the asylum, and entered as suffering from mania-a-potu. He made a good recovery, and stated that for some days he had been haunted by the idea that he should drink whisky, not that he cared for it or wanted it, but still the idea kept coming before him, and at night it kept him awake. He could think of nothing else. He said it seemed as if some misfortune would come upon him if he did not drink, so he gave way. He remembered a kind of mad delight when he did so. If he knew it was poison he said he could not have prevented himself from drinking it. It seemed as if his nerves or mind got upset before he-

took the drink. Fervently he said he would never, never drink again, and I am quite sure he earnestly meant what he said. Yet within a year he was again admitted to the asylum, and went through pretty much the same course. Since then his family had become alive to looking after him, and five years have elapsed since his last attack, but I am informed that at about the same time each year he has had to leave his work for three or four weeks, during which it was with the greatest difficulty he was restrained from "breaking out." Last month he "broke out," and now seems to be physically and mentally breaking down. Truly a case of obsessional insanity leading to drink, and drink leading to acute alcoholic mania.

Of acute alcoholism or drunkenness it is unnecessary for me to say very much, for such cases are usually dealt with by the general practitioner or the police. However, they are of interest, as they constitute miniature cases of insanity running through the several phases—elation, exaltation, depression, and stupor—in the course of a few hours. Epileptiform convulsions may be noticed in a certain number of cases, and in these the mental disturbance often lasts for some days. during which they are liable to be mistaken for epileptic insanity, and committed to the asylum. D. G. is such a case, admitted here recently as an epileptic maniac. He had been on a drinking bout, had an alcoholic (epileptiform) seizure, was sent here, where under good feeding and no drinking he quickly re-covered and will be discharged in a few days. You will observe the absence of that dull, confused apprehensive expression of countenance which is so notice-

Delirium tremens is another class—or rather degree—of alcoholic insanity, more frequently treated outside than within our asylums, and as it comes into the general hospital course I will not occupy much of your time with it. It commonly occurs in those who habitually drink freely, and who have recently been indulging to an abnormal extent. Curiously enough. we find that in many instances a distaste for drink accompanies the first symptoms of the disease, and then we are told that it was the sudden stopping of the drink that caused the upset. A chill, a shock, or an accident is often the determining cause of the break-

able in the average sufferer from epileptic mania.

Restlessness, irritability, loss of appetite, disturbed sleep with fearful dreams, soon total loss of sleep. hallucinations of a terrifying character haunt the sufferer; he is muttering, incoherent and wandering, or shouting in terror. It is difficult to fix his attention. He is liable to mistake those about him for enemies, and to make violent attacks on them under the misapprehension that they are trying to injure or kill him. The suspicions of the habitual drunkard are exag-

gerated in delirium tremens.

The physical symptoms: Face flushed, conjunctiva suffused; the tongue tremulous, thickly furred, becomes dry as the disease progresses; pulse quick, soft. and full at first, later small and irregular. The temperature may rise to 102°, but it seldom goes above 101° in uncomplicated cases. The skin is moist or perspiring, the urine scanty, dark-coloured, and

high sp. g.

In favourable cases at the end of the third or fourth day marked improvement takes place. Sleep may come on naturally and last for ten or twelve hours. when the sufferer may awaken much refreshed, the delirium and trembling are lessened and general improvement follows pretty quickly. In unfavourable cases the pulse is quick and feeble, the delirium of a

milder type, the face pale; the patient lies on his back in a semi-comatose state; convulsions may supervene, followed by exhaustion and death, or hyperpyrexia may herald the end.

Treatment.—In all cases of delirium tremens one should be prepared for and guard against heart failure, which is liable to occur even when good progress to wards recovery seems to have been made. The patient should be kept as quiet as possible in a subdued light, but total darkness must be avoided because it tends rather to aggravate the terrors. To promote sleep and build up the patient's strength are the points to be aimed at. Plenty of nourishment must be given in small quantities at a time, milk and eggs being chiefly One must be very careful in prescribing drugs. Chloral, in doses of 15 to 20 grains, may be given every six hours, and bromidia is a preparation which I find particularly useful in these cases.

It is a debatable question whether delirium tremens cases should be sent to asylums or not. No doubt we are more suitably equipped for dealing with them than general hospitals. We have trained attendants to care general hospitals. We have trained attendants to care for them, small isolation rooms, padded rooms, and grounds for air and exercise during convalescence. Against all this is the fact that certification as insane involves many disabilities; it shuts a man out of prac-fically all public services, and lowers the value of his life for insurance purposes, etc. So, all things considered, it is only in extremely violent cases that the asylum should be resorted to.

Diagnosis may be confused with acute delirious mania, but with the history of the case, and remembering that in the latter the hallucinations are not terrifying, there need be little difficulty. The delirium of pneumonia in drunkards is liable to be mistaken for it, but physical signs easily settle the question.

Mania-a-Potu occurs in persons of temperate habits who, being of neurotic taint, give way to drink for a short time. In them the intoxication seems to continue for some time. In a general way the mental symptoms resemble delirium tremens, but the expression of terror is seldom very striking, the tremor is absent or only trivial, the patient does not look ill or broken down, and he generally recovers within a few days

D. G. is a case of this class. Admitted three weeks ago for assaulting a policeman, he was in a very restless, noisy, excited state for three days, when he fell exhausted into a sleep of about 15 hours. Since then he has been quite tranquil, recognises that his mind

was upset, and says he mistook the policeman for a man he thought was on the watch to injure him.

C. E. is an interesting example of the alcoholic development of latent defects. His family history is very unfavourable. Two brothers are cases of ordinary epileptic mania, an uncle suffered from chronic delusional insanity, and other relatives are known to have been insane. He served as a soldier of good record up to five years ago when he went on a drinking bout, had an epileptiform seizure, followed by maniacal excitement and delusions of persecution against an officer. He was committed to the asylum and made a speedy recovery. He was discharged and worked as a labourer for nearly a year, when he again drank heavily for three days; as before, he had an epileptiform seizure, followed by a severe attack of mania, same delusions as previously, and made a good recovery within two months. Since then he has been discharged and readmitted three times; same course, but recovering more slowly on each occasion. He was last admitted three months ago, and you see the delusion of being followed by the officer still continues with the further development that he threatens to shoot his persecutor whenever he gets the chance. Probably the delusions have now become permanent. It is only under alcoholic influence that the seizures occur.

Closely allied to the above is the recurrent insanity of the common drunkard. He is generally one of little strength of character, he lacks inhibitory power, and is largely the creature of habit. If with drinkers, and in the way of it, he drinks; if not, he may continue temperate for a long time. As our patients express it, "I could take it or let it alone, company does it,"
"I never cared for drink." These people form an intermediate class between mania-a-potu and chronic

alcoholic insanity. The symptoms are less severe, the duration longer and the probability of recurrence much greater than in the former; the constitutional enfeeblement in early attacks is trifling, the appetite and general health recovering quickly when alcohol is withheld. Hallucinations and delusions are indefinite and very temporary, and restoration is accomplished in a week or ten days. With recurrences recovery becomes slower, delusions and hallucinations obtain a firmer hold and gradually they merge with the ranks of the chronic alcoholic maniacs and dements. unfortunate that the law does not afford some means of restraining these people in the early stages of degeneration, to protect them from their own weakness and the ratepayers from the burthen of their main-tenance when they have reduced themselves to the

stage of absolute uselessness.

Chronic Alcoholism and Chronic Alcoholic Insanity.-These are forms of mental derangement which result from steady drinking for a prolonged period. The alcohol is taken in small quantities, frequently repeated. Some confusion and impairment of memory, restlessness and irritability of temper, degradation of character, tendency to lie and use filthy language, may exist for some time before any very definite symptoms appear. Sensory and motor disturbances are frequently complained of, while gastric and digestive troubles are not uncommon. As the malady develops there is a general weakening of the intellectual faculties. The memory, particularly for recent events, becomes markedly defective, paramnesia is frequently present, attention fails, the patient grows suspicious and anxious; he is no longer able to attend to his ordinary duties, and soon he becomes incapable of looking after himself; abnormal sensations are experienced, due to the action of the alcohol on the nervous system. These are usually the starting points of hallucinations and delusions, the patient attributing them to external influences. His failure in business and general breakdown he persuades himself are caused by an enemy, and his sensations or hallucinations he believes to be a continuation of the persecution, it may be through electric or hypnotic influence. That poison is being put into his food or puffed in at the keyhole is frequently complained of; alterations of senses of taste and smell are frequently found in such cases; the delusion of poison originating in hallucination of taste, coupled with the idea of persecution. The persecutory delusions are generally in relation to some near associate, such as wife or husband. The above is practically the case of this patient M. B. To his wife, as you see, he attributes all his misfortunes. The immediate cause of this patient witch when the mode a wielant attack on of his committal was that he made a violent attack on her, under the belief that she attempted to poison him. His insane inconsistency is noteworthy. He explains His insane inconsistency is noteworthy. He explains that she put poison in his tea, but that when she looked away he exchanged her cup for his own, and although she suffered no ill-effects from drinking that which was intended for him he still believes it was poisoned.

The insanity of chronic alcoholism is liable to be mistaken for general paralysis of the insane. Exalta-tion and extravagance may occur in either, but the general paralytic tends to buy quantities of the same thing (a general paralytic lately admitted here had 26 watches on him); the alcoholic goes in for more variety. The general paralytic seldom attempts to reason or explain his delusions; he simply makes wild delusional statements of wealth or power, but does not explain much how he came by it. The alcoholic with the same delusion will explain how he came in for it, how successfully he invested it, etc.

In the chronic alcoholic the knee reflexes are usually absent or diminished; in general paralysis they may be increased, particularly in the early stages.

In both the tongue is tremulous, but in general paralysis it is ataxic also.

There is greater loss of facial expression in general paralysis. The pupils are usually unequal and often irregular in general paralysis. Headaches favour diagnosis of general paralysis.

Expression of terror is more frequent in alcoholism than in general paralysis; vivid visual hallucinations frequent in alcoholism, rare in general paralysis. The history of the case is naturally of much assistance.

If chronic alcoholism, the patient has been pretty steadily tippling for years; if general paralysis he is more likely to have developed his intemperate habits suddenly, and to have gone to extremes at once, for the general paralytic does everything in extremes.

The prognosis in such cases is unfavourable; yet we see very unpromising ones make pretty good recoveries, particularly if a first attack. Age is, of course, an important factor, those of advanced years tending to run into dementia. Profound loss of memory in a young person is unfavourable. Even in those regarded as good recoveries there is almost invariably a perceptible degree of mental enfeeblement left. I certainly cannot call to mind a case in which a patient quite regained his normal strength of mind.

The treatment consists of removal of the cause, generous feeding, which it may be necessary to forcibly administer in some cases. Sulphonal and trional are about the most satisfactory hypnotics in all alcoholic cases except delirium tremens. As convalescence progresses it is of importance to afford much outdoor exercise, cheeriness of surroundings, and generally to enkindle a bright view of life, with hope and prospect for the future. In some a sense of despondency occurs during convalescence, which must be combated, lest melancholia should supervene. As a rule, in these, as in most other forms of insanity, one of the best guides we have to gauge if recovery has taken place is to find that the patient recognises his mind had been upset, and that he fixes a period at which he found himself regaining his senses.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by George H. Savage, M.D., F.R.C.P. Lond., Consulting Physician and Lecturer on Mental Diseases, Guy's Hospital; Consulting Physician to Barlswood Asylum, &c. Subject: "The Feeble-Minded and their Care."

#### ORIGINAL PAPERS.

# RUPTURE OF THE UTERUS DURING LABOUR, (a)

By T. B. GRIMSDALE, B.A., M.B.CANTAB., Henorary Gyamoological Surgeon, Liverpool Royal Infirmary; Lecturer on Clinical Gyamoology, University of Liverpool.

RUPTURE of the uterus has been for long divided into two great classes:—

(1) Complete rupture, where the tear extends through the uterus muscle and through the peritoneum.

(2) Incomplete rupture, where the tear does not involve the peritoneum.

The present remarks will be confined to the con-

The present remarks will be confined to the consideration of complete rupture of the uterus.

The classical signs of rupture of the uterus are well known to all. There is, during labour, sudden severe pain, profuse bleeding from the vagina, great shock, and a cessation of all uterine contractions. With these symptoms anyone would at once recognise that rupture

of the uterus was a probability.

It is a very rare accident, but these classical symptoms are so alarming, and have been so graphically set before us, both in text-books and in the medical papers, that they are burned into our minds deeply and I fancy there is no one that has not pictured to himself this terrible accident, with all its dramatic surroundings, and who has not in all probability sketched out for himself some method of procedure should this accident happen to any patient that he is attending; and this is as it should be.

But these classical symptoms do not always occur in eases where there is rupture of the uterus, and then it is that mistakes are made in diagnosis, not from want of care on the part of the doctor, but from a too graphic and absolute a presentation of the accident on the part of the text-book.

The symptoms of rupture of the uterus are not always definite, as in the classical book illustration, and the term "silent rupture" has been used to denote the cases

(a) "Liverpool Medico-Chirurgical Journal," January, 1909.

of rupture of the uterus which occur without severe symptoms. Many such cases have been reported, where the doctor in attendance has not suspected the accident, and where the patient has died from septic infection or hæmorrhage, and the rupture of the uterus has only been discovered at the autopsy.

Such a case was reported by Dr. Barber, at the North of England Obstetrical and Gynæcological

Society, in 1904.

A woman was admitted to the Jessop Hospital. She had been delivered that day by version, after forceps had failed. She was said to have a laceration of the vagina. The House Surgeon reported to Dr. Barber that there was apparently nothing urgent about the case. She was 32 years of age, obese, two previous labours had terminated normally. The history was of onset of labour on November 1st, rupture of membranes November 2nd, and delivery on November 4th. She had no anxious expression, no restlessness, and did not complain of pain. The temperature 102° F. pulse 126. The abdomen moved with respiration, and was flaccid. The fundus uteri could be felt above the pubes; it was firmly contracted and somewhat tender, but not unduly so. Vaginal examination was difficult, but the cervix felt ragged and a tag depended from it. The urine contained a little blood at first, but none later. The patient remained comfortable all day, but pneumonia developed in the evening. Next morning the patient expressed herself as being very comfortable, but suddenly, a little time after an evacuation of the bowels, she became very ill and died in a few minutes, and without exhibiting any of the classical signs of internal hæmorrhage. Autopsy on the same evening: Abdomen enormously distended by gas in intestines and stomach; no signs of peritonitis; peritoneal cavity contained much free recent blood, and there was some in the broad ligaments, chiefly on the right side. There was rupture of the uterus, limited mainly to the lower uterine segment, and involving the peritoneum. The rent was posterior, and ran obliquely upwards from right to left. Bandl's ring was very conspicuous. Dr. Barber invited opinions as to what sign or group of signs could be taken to indicate the serious condition.

In considering the case, I should with some diffidence suggest that the long labour in a multipara, the delivery by version after the failure of forceps, the laceration, the temperature and pulse, would quite justify an abdominal operation, although I know that it is easy to be wise after the event.

In the last few years I have seen four cases of rupture of the uterus. All of these have been very similar in the position of the rupture and in its extent. The rupture in each case was L-shaped, and occupied the lower part of the uterus. The transverse tear ran across the cervix and sometimes extended to the vagina; and the perpendicular portion of the tear ran up the side of the uterus, in one case tearing through the uterine artery, causing so severe a hæmorrhage that the patient died. In all the cases the tear was so bruised and ragged that it seemed to me absolutely impossible to sew up the tear. In three of the cases the patients were taken into the Royal Infirmary as soon as possible after the occurrence of the rupture. In each of these cases the child had been delivered per vias naturales before the patient came into hospital. Each of these had presented the well-known symptoms, and in each had the condition been correctly diagnosed at once before her admission to the infirmary. treatment adopted in each case was the same. abdomen was opened and the entire uterus removed. Two of the cases recovered; one died. In the case that died the uterine artery on the right side had been ruptured, and the patient had almost bled to death before she arrived in the hospital; but the operation was performed to give her a chance of life, but failed. She died about twenty minutes after the completion of the operation-that was, about four hours after the accident.

The case to which I wish to draw special attention was unlike the rest, and because of this I mean to relate it more in detail. In the first place, the accident occurred without presenting the usual alarming symptoms, and it was not until 48 hours after the

labour that the accident was discovered, and yet she was attended by a careful midwifery expert, and the reason that the accident was then discovered was owing to the occurrence of intestinal obstruction.

Mrs. T., æt. 35, four children, had always had very rapid labours. On Saturday she was taken in labour, and sent for Dr. E. T. Davies, who had always attended her in her confinements, but who had never been able to arrive before the baby had been born, owing to the rapidity of her labours. On this occasion the messenger arrived at Dr. Davies' house about 6.30 a.m. Knowing the need for haste, Dr. Davies left on his bicycle and pedalled off to the patient, about 21 miles away. When he arrived he found, as usual, that the child had been born, the labour only having lasted about half an hour, but he discovered on examination that there was a second child in the uterus which was in a transverse position. He now found himself in a rather awkward position, because in his hurry to be in time he had not taken any chloroform with him. He therefore was compelled to turn without an anæsthetic. This he did, and delivered the child and placenta. The patient stood it well, but vomited soon after, and continued to vomit off and on all day.

The next day the patient was very sick, and there was considerable distension of the abdomen, more

especially in the upper part.

On the Monday, about 48 hours after the confinement, Dr. Davies asked me to see her, as she was still vomiting, and she had not passed any flatus since the confinement. The distension of the abdomen, too, had increased; the pulse 161, and the temperature 99.50 The patient was rathed excited, and looked anxious and ill, but talked quite freely and rationally.

On examining the abdomen, it presented a most peculiar appearance and shape. The lower part of the abdomen up to the level of the umbilicus was comparatively flat, and quite dull on percussion; above the umbilicus there was enormous distension, and the percussion note was tympanitic. The intestines seemed to lie almost together above the umbilicus. This was so marked that it looked as if the abdominal cavity were divided into two compartments by a semi-circular line drawn from each anterior superior spine to a point about one inch above the umbilicus. The abdomen was very tender, and examination was difficult. abdomen moved very little on respiration.

On making an examination per vaginam, a laceration could be felt in the posterior vaginal fornix, and a

knuckle of bowel was felt in the vagina.

The patient was removed to the Royal Infirmary, and the abdomen was opened in the mid-line. There was much fluid blood in the abdomen, with some clots. The uterus was pulled up to the abdominal wound, and it was seen that there was a ragged tear of the uterus, and protruding into the vagina was a loop of intestine which had become adherent to the sides of the tear. The intestine was freed and washed. The uterus was then removed entire, the vagina closed, and the patient returned to bed. No drain was used. The patient recovered well.

The tear in the uterus was L-shaped, the transverse portion of the L running across the posterior surface of the lower uterine segment about one inch above the vaginal cervix. The upright portion of the L ran upwards along the right side of the uterus, and extended for about three and a-half inches along the course of the uterine artery, but did not tear it. From the left side of the transverse portion of the L a tear ran downwards into the posterior wall of the vagina for about two inches.

Rupture of the uterus is one of the most serious accidents that can happen in labour, and it is still a very fatal accident. It is rather difficult to know what the mortality of the accident is at the present time, but it must be considerable, although it has altered in the last ten years enormously for the better. Much still depends on the site of the rupture, and also upon the promptitude of the doctor, but still more, perhans on the situation of the patient, and whether the accident occurs in hospital or in private practice. It is interesting to recall the figures given by Spiegel-berg of the mortality of rupture of the uterus. He

says that 95 per cent. of the cases of rupture of the uterus die.

Of course this estimate of the mortality was made years ago, before the improvements in the technique of abdominal operations came into vogue, and at a time when abdominal operations were not resorted to except as a dernier resort.

Now, I suppose any case of rupture of the uterus would be at once treated by abdominal operation, as this holds out the best prospect of life to the patient.

Schultze gave statistics of 193 cases collected about 1906. Complete rupture without treatment, 20.2 per cent. recovered; complete rupture treated with drainage only, 36 per cent. recovered; complete rupture treated

by laparotomy, 44.7 per cent. recovered.

Ivanoff (Annales de Gynécol. et d'Obstét., Aug., Sept., Oct., 1904) analyses 124 cases collected between 1877 and 1901; 80 cases occurred at Moscow Maternity. He gives the frequency of rupture 1 in 1,482 cases. Koblanck gives 1 in 462 cases. In the 124 cases the mortality was 81.75 per cent. All these were treated by gauze plugging and abdominal bandage. Of 58 cases of complete rupture, 7 recovered, giving a mortality of 87.75 per cent. Of 43 incomplete, 16 recovered; mortality, 61.18 per cent.

Ivanoff believes the fatal issue can only be prevented by operation. Of cases treated by abdominal section there were 60 per cent. recoveries, against 27 per cent. by expectant method. Ivanoff says all the so-called pathological modifications of elastic tissue of uterus as described by some authors are really physiological. He says the treatment of every rupture of the uterus during labour should be by operation, for by this means alone can the bleeding be arrested, and the region of the wound and the peritoneal cavity thoroughly cleansed.

The causes of rupture of the uterus are various, but they may be divided into two classes—traumatic and spontaneous. Milne Murray (Journ. Obstet. and pontaneous. Milne Murray (Journ. Obstet. and ynacol. British Empire, Vol. I.) divides them as follows :-

Traumatic-

Direct mechanical violence-

Forcible introduction of hand into Internal Unskilful performance of internal Traumatism. version. Improper use of forceps.

It need hardly be said such cases should not occur.

External External violence, blows, falls, etc. Traumatism.

Spontaneous. In cases of spontaneous rupture we assume that the immediately determining cause is the contraction of the uterus. Predisposing causes are various. The majority of cases are associated with some condition arising out of abnormality of either of the two factors of labour, passage or passenger.

Given any condition which interferes with or delays the dilatation of the os, the lower uterine segment becomes thinned out, while the muscular tissue of the upper segment gathers itself together into a sort of cap on the upper pole of the uterine mass. The strain on the thinned-out lower segment increases until it gives way. A tear so produced will tend to run across the long uterine axis, though the general direction of the tear may be altered by the splitting produced by the escape of the uterine contents. the developed tear may run obliquely or directly upwards.

If, on the other hand, the thinning-out of the lower segment is associated with contracted pelvis, the position of the rupture may be determined by the grinding of some portion of the thinning segment between the fœtal head and some bony ridge. A contused area may thus be formed in which the rupture may begin, in a transverse direction at first, and end vertically or obliquely. Or it may be that the point of rupture may be determined by an excessive thinning-out of the uterus over some prominent point in a mal-presenta-tion, such as a chin in a face case or occiput or shoulder in a transverse. Milne Murray further says: spontaneous rupture may occur, however, in certain cases without any process such as described by Bandl. There

may be no abnormal obstruction to the escape of contents.

 Interstitial pregnancy.
 Abnormal conditions—uterus bicornis, myomatous uterus, previous Cæsarean section.

3. Small number of cases where rupture occurred at beginning of labour, no abnormality found in uterus. Rupture of the uterus is in all probability a much

more frequent accident than is generally supposed; and seeing that autopsies are seldom made in private practice, it is not unlikely that many of the cases of mysterious death occurring three or four days after labour are in all probability due to unsuspected rupture of the uterus; also some cases doubtless recover.

I remember, many years ago, seeing a case of rupture of the uterus in a young unmarried girl. There was no doubt about the rupture, as the fœtus had escaped into the abdomen, but it had been delivered per vias naturales when I saw her. I advised operation, but this was refused. For two days she seemed likely to recover, but on the third she got up to pass water, and was suddenly seized with severe abdominal pain and died in a few hours. The patient was under the most unfavourable surroundings and amongst very obstinate people. There was no skilled nurse to attend to her; if she had had any proper attention it is possible that she might have recovered even without operation

This is the only case that I have seen of undoubted rupture of the uterus that has had no operative treatment; but there are statistics of the results of rupture of the uterus treated expectantly, and the results are very bad indeed—about 90 per cent. mortality. There are those who still advocate plugging and draining the tear, as being the safest treatment of complete rupture of the uterus. Amongst these are H. R. Spencer, who read a paper before the Obstetrical Society of London (Obstet. Trans., XLII.), and the general opinion in the discussion that followed favoured his views; also in the Journal of Obstetrics and Gynacology of the British Empire, July, 1908, Dr. Munro Kerr, in an elaborate paper on "Rupture of the Uterus," is inclined to side with Spencer; but in the last few years there is no doubt that opinion is gradually forming more and more in favour of abdominal operation for the treatment of complete rupture of the uterus.

Personally, I feel sure that where there is undoubted complete rupture of the uterus there is only one course to pursue, and that is to operate at once—open the abdomen, and deal with the condition found. In all probability the best course will be to remove the uterus; it must be very exceptional to find a tear that can be satisfactorily sewn up, although this has occurred. But even if the tear is sewn up there are considerable risks that have to be run in adopting this method of treatment. In the first place, there is always the danger of sepsis. In these cases there has in all likelihood been a prolonged labour, with manual or instrumental interference, and possible infection of parts before the operation is undertaken. Secondly, if the suturing of the tear has not been perfect, there may be a leak of the lochial discharge into the peritoneal cavity during the puerperal period. Thirdly, if the operation has been successful, the scar in the uterus will be a weak place, and there may be a rupture at a future confinement. So that in all probability the safest measure in a case of rupture of the uterus is to remove the uterus; and it is safer to remove it by the abdomen than by the vagina, because there will be much blood in the peritoneum that will require 10-moval, and the bleeding vessels are more easily and rapidly tied by the abdomen. As Nelson once marked, "the boldest measures are oft the safest."

# OUGHT TEA, COFFEE AND CHOCOLATE TO BE FORBIDDEN IN URICÆMIA.

By PROF. ALFRED MARTINET, M.D., Of the Faculty of Medicine of Paris

SPECIALLY REPORTED FOR THIS JOURNAL.

In certain diseases and constitutional states excessive quantities of uric acid are excreted; even the blood, according to Garrod, contains an excess

thereof. It is met with in excess in acute diseases, such as pneumonia and hepatic cirrhosis, especially the atrophic form, when it forms a copious deposit in the urine. The facts are familiar to everyone, but the interpretation to be placed thereupon is still far from clear.

Considerable progress has been made in the study of uric acid during the last few years. It has been shown that the greater part, if not the whole of it, is derived from the nucleins (nucleo-albumens and nucleo-proteins) contained in the cell nuclei, and in the purin bases, such as xanthine, hypoxanthine,

guanine, adenine, &c.

In opposition to the generally-received view, however, it is not to be regarded as a product of incomplete oxidation of albuminoid substancesi.e., an intermediate product between these and urea, and there is no relationship between urea and uric acid, since repeated dietetic observations have amply demonstrated that the nitrogenous excretion can be varied at will by a purin-free, but more or less nitrogenous, diet, the proportion of urinary purins remaining the same.

As a matter of fact, uric acid and the xanthein derivatives (xanthine and hypoxanthine), which are found associated and are described under the generic term, xantho-uric compounds, are derived from the disintegration of the cell-nuclei (endogenous); from the disintegration of the alimentary

nucleins or purin bodies (exogenous).

Repeated experiments have shown that in the normal individual a purin-free diet determines an invariable minimum of endogenous uric and xantho-uric excretion. This endogenous minimum appears to amount to from 0.40 to 0.50 gramme for the total purins, and from 0.30 to 0.35 for uric acid alone. These proportions may rise to a high level in certain pathological states (pyrexia, pneumonia, leucæmia, pernicious anæmia, &c.). As for the exogenous xantho-purins, their proportion varies according to the richness of the diet in these bodies. This comprises about all we know concerning the intra-organic formation of the xantho-uric compounds. Their pathological rôle still remains in great part to be worked out.

The interpretation to be placed upon the pathological phenomena in which uric acid appears to play an important part-attacks of gout, urinary lithiasis, articular pain, migraine, etc.—cannot be inferred from a comparison between the proportion of purins ingested and that of the xantho-uric bodies excreted. As a matter of fact (1), many persons placed on a dietary comparatively rich in purins never suffer from uricæmic accidents; not anyone can become gouty. (2) In certain pathological states, such as pneumonia after the crisis, and in leucæmia, there may be marked hyperuricæmia and hyperpurinia without this surcharge of the blood and urine, in respect of xantho-uric bodies giving rise to any of the uricæmic disturbances popularly

ascribed to the uricæmic state.

It will be seen, therefore, that the pathogenic problem is of a very complicated nature, and for a uræcemic accident to occur three factors appear to be necessary, and possibly suffcient-viz.: (1) A certain degree of hyperuricæmia; (2) a certain degree of impermeability of the kidney in respect of the xantho-uric bodies; and (3) a peculiar state of the xantho-uric bodies that renders them more prone to undergo precipitation within the tissues. We know that hyperuricæmia has been found to

exist in the blood of the gouty at a certain stage of the disease. Garrod, indeed, found as much as 0.01 gm. of uric acid per cubic centimetre of the blood, whereas in healthy subjects, at most, a trace can be discovered. This proportion seems quite inadequate per se to determine uricæmic accidents. Although in many gouty subjects there is unquestionably more or less renal impermeability, the influence of this factor is open to question. It would seem that, just as in diabetics in respect of carbohydrates, and in certain renal patients towards salt, gouty and uricæmic subjects, or some of them, have a limit of tolerance for purin-containing foods.

It has long been an article of belief that the quantity of uric acid in the blood undergoes variations in deference to circumstances still ill-understood. Recent researches have verified this assumption, and have also thrown light on the conditions that govern the solubility of uric acid. For instance, it has been shown that thyminic acid, a constant product of the breaking-down of nucleinic acid, and therefore of the nucleins, dissolves more than its own weight of uric acid at a temperature of 37° C., forming a stable compound which is with difficulty precipitated by acids. Nucleinic acid possesses very similar properties, so that uric acid derived from organic nucleoalbumens is normally accompanied by its natural solvent.

Moreover, many causes, still imperfectly known, may render uric acid more or less precipitable, whether, as suggested above, because it forms peculiarly soluble and barely precipitable compounds, or because it is oxidised and undergoes transformations which have the same effect, or, again, because, on the contrary, the presence in the blood of certain substances, such as tarmin, and sundry mineral salts, facilitate its precipitation.

It is unnecessary to insist on the importance of the last-named pathogenic condition, which possibly

overweighs all other factors.

The view that ceteris paribus, and according to the diet, uric acid is, or is not, soluble, at any rate, to any great extent, by hydrochloric acid, has been very cleary shown by Fauvel, who demonstrated that on a milk or vegetarian diet, free from purins, uric acid is not precipitable by hydrochloric acid, whereas on a meat diet it is so.

It is, however, impossible to draw a satisfactory, comprehensive explanation from these data. If we limit ourselves to what is known of the symbiosis—thyminic acid and uric acid—we might suppose that only the alimentary purins which do not form part of any complete nucleinic compound, and are, therefore, not accompanied by thyminic acid, are capable of yielding uric acid precipitable by hydrochloric acid.

Clinically, we meet with a certain number of subjects who almost invariably pass urine that precipitates merely on cooling, leaving a more or less copious deposit of a red colour, resembling brickdust. This sediment is composed principally of

uric acid and its derivatives.

Independently of patients suffering from acute pyrexial disease, pernicious anæmia, leucæmia, &c., in whom uric acid is always present in excess in the urine, this symptom is met with in persons who habitually consume large quantities of food rich in purin bodies: meat, fish, the legumens, chocolate, tea and coffee. We may endeavour to explain this by assuming the presence in the blood of a fairly large quantity of readily-precipitable xantho-uric products, and, if so, what conclusion is to be drawn from the organic point of view? It may not improbably be due to the presence in the blood of xantho-uric compounds of the same kind as those found in the urine, that is to say, in a state of unstable solubility, and therefore easily precipitated, and pro tanto injurious. This would suggest the desirability of trying, either for curative or

preventive purposes, to keep down the organic proportion to a minimum by suitable dieting, the only really and certainly efficacious means at our

disposal to obtain this result.

Be it remarked in passing that this hyperpurinia is, after all, a defensive reaction, an attempt to get rid of injurious bodies, and it may for a long time fail to give rise to any appreciable disturbance, the latter being dependent on the subject's limit of tolerance. It is easy to imagine, on the other hand—a fact that is often witnessed in gout—that urine poor in uric acid, such acid not being very precipitable, may be associated with an injurious degree of hyperuricæmia. From the pathogenic point of view, the most important is not the uric acid that is found in the vase, but, on the contrary, the uric acid that is left elsewhere. Nevertheless, habitual hyperpurinia is presumptive evidence of great value as indicating threatening hyperuricæmia, of xantho-uric super-saturation of the blood, with all its possible consequences in the event of precipitation under the influence of some accidental cause-chill, over-work, over-feeding, alcoholic excess, &c.

Our duty in such cases is, therefore, to suppress, or, at any rate, to restrict, the intake of foods containing nucleins and purins. Foremost among these are tea, coffee, cocoa, alkaloidal infusions or solutions, the latter being almost pure purins; 100 grammes of chocolate contains about 1 gm. 50 of theobromine; 100 grammes of coffee about 1 gm. 50 of caffeine; 100 grammes of tea 2 gm. 50 of theine and adenine. These purins are methyl-xanthins, the composition of which closely approximates that of uric acid and the xantho-uric bodies, thus justifying Haig's dictum that "coffee is really uric acid." It is therefore usual and rational to absolutely forbid the use of alkaloidal purinic drinks in the subjects of uricæmia.

Yet, before arriving at a definite conclusion, the question deserves to be thoroughly investigated. In a series of carefully carried-out dieteto-urologic observations, Fauvel found that with coffee and chocolate a seventh part of the theobromine, and a third of the caffeine, re-appeared in the urine in the form of purins, but these methyl-xanthins did not increase the proportion of uric acid, and the latter was not precipitated by hydrochloric acid. According to this same author, if theobromine or caffeine be added to urine in vitro, the uric acid of which is readily precipitated by hydrochloric acid, there is a well-marked decrease in the amount of acid precipitated.

It will be perceived that another factor comes into play here—vis., that very important factor of the variable solubility of uric acid compounds, and it may be asserted, indeed, that although tea, coffee and chocolate increase the proportion of xantho-uric compounds in the urine, and probably also in the blood, they also enhance its solubility.

Fauvel's experiments, however, do not warrant any definite conclusions:—(1) Because they only bore on a single subject whose renal permeability and purin-metabolism were normal; (2) because the experiment only lasted five days for chocolate, two days for coffee, and in respect of elimination, the observation only bore on the trial days, and not on the following days; (3) because it tells us nothing about the destiny of six-sevenths of the theobromine and two-thirds of the caffeine which were not discovered in the urine, and it is just this fraction that is of most importance. Is it eliminated daily in some form that eludes our present methods of analysis? Is it transformed and destroyed in the organism? Does it, on the contrary, accumulate

there, and subsequently provide material for the xantho-uric excretion? This we do not know.

We must certainly take Fauvel's researches into account, but it would be premature, and even

dangerous to accept them as a guide.

We must look to clinical experience to decide our line of conduct, and clinically we daily meet with subjects who suffer from various arthritic manifestations, the determining cause of which is clearly the abuse of tea, coffee and chocolate; in these subjects, indeed, simply withdrawing tea, coffee and chocolate causes these manifestations to disappear, apart from any other change of regimen. Among numerous observations, we may mention one bearing on a woman, æt. 20, who daily consumed large quantities of tea, and suffered from more or less chronic rheumatoid, articular pain, the right kidney being palpable and tender, and the urine being muddy, containing 1 gm.o2 of xantho-uric bodies. In this case complete withdrawal of tea, without any other change in her habits of life, brought about the subsidence of the troubles within three weeks, and the proportion of xantho-uric bodies fell to o gm.69. Conversely, in a man of 63, previously free from any rheumatic tendency, we have witnessed the supervention of very refractory rheumatoid pains after taking large quantities of chocolate for eighteen months, and medical literature teems with similar instances.

In practice we must, for the time being, adopt

the following conclusions:—

1. Alkaloidal beverages, especially tea, coffee and chocolate, should be forbidden for uricæmic subjects, especially those whose urine spontaneously precipitates uric acid.

2. Nevertheless, the action of coffee and chocolate appears to be less injurious to the organism than that of meat and the legumens, the latter appearing to predominate, for although uricæmic manifestations are specially frequent in meat-eating races or tea drinkers (Anglo-Saxons), it seems to be rather rare in people who are vegetarians, though they drink tea and coffee (Japanese, Hindus, Arabs, etc.).

In short, tea, coffee and chocolate may be allowed in moderation when the food is principally vegetarian and hypopurinic, but they should be strictly forbidden when the diet comprises much meat, which is the case in most instances of "excretors

of uric acid."

# DISINFECTION OF HOUSES IN INDIA, (a)

BY DR. SORAB C. HORMUSJEE, Assistant to the Health Officer, Bombay Municipality.

In the course of his paper Dr. Sorab said his main object was to give an outline of the methods of disinfection in vogue in Bombay City, and which of them are most effective, convenient, and economical. The Indian Plague Commission, he said, appointed in the year 1898, after carrying out certain experiments, came to the conclusion that an acid solution of perchloride of mercury of the strength of 1 in 1,000 was a chemical disinfectant that was most likely to render efficient service in plague-infected houses. But within the last two years the researches of the Second Plague Commission which were carried out at the Bombay Bacteriological Laboratory, and which have con-clusively brought to light the fact that the plague is communicated to man from rats by means of rat-fleas, have brought about a considerable alteration in the method of dealing with plague-infected houses.

This important discovery—viz., that plague is communicated from rats to rats and from rats to man by means of the rat-flea-suggested the use of a pulicide, because we are now in a position to know that plague bacilli exist in nature either in the body of a plague-sick animal (chiefly the rat) or in the stomach of a rat-flea which has fed on such an animal. Perchloride of mercury, although it is a powerful bactericide, is not an insecticide. In the light of these recent researches, therefore, regarding the manner in which plague is com-municated, perchloride of mercury is useless as a disinfectant for plague-infected houses. Since August, 1906, Dr. Turner, Executive Health Officer, Bombay, introduced the use of pesterine as a disinfectant for houses infected with plague. The word "pesterine" is merely used for convenience of ex-pression. This substance is crude petroleum (fuel oil), and is undoubtedly a powerful insecticide, as it instantly kills all fleas, bugs, and other insects that come in contact with it. The Director of the Bombay Bacteriological Laboratory has recently suggested the use of kerosene oil emulsion for the disinfection of plague-infected houses. This emulsion is prepared by dissolving 3 parts of Sunlight soap in 15 parts of water by boiling. Warmed kerosene oil is then to be added to this soap solution gradually up to 100 parts. Finally the oil and soap water should be mixed together by shaking or stirring the mixture. The same officer also recommends the use of hydrocarbon emulsion, which is prepared in a similar manner to kerosene oil emulsion, except that the hydrocarbon is not warmed. PLAGUE BACILLI.

Although as a rule the plague bacilli exist in the stomach of a rat-flea which has fed on an infected animal, it is by no means certain that they do not exist in other substances. For instance, the excreta of sick animals or man also contain them. The second Plague Commission, in one of their reports, state that the plague bacilli, when present in such excreta, are as a rule rendered quickly harmless either by desiccation or by the development and multiplication of saprophytic bacteria, which are inimical to the existence of plague bacilli. The fact, however, of the existence of these bacilli in places other than the stomach of the flea, necessitates the use of some disinfecting agent which has both pulicidal as well as bactericidal powers. end in view, our Municipal Analyst, Dr. Ghadially, suggested, in August, 1907, the use of kerosene oil emulsion mixed with cyanide of mercury. The latter chemical is as powerful a germicide as mercuric chloride, and has the advantage of not being precipitated by albumen, gelatin, mucin, and organic matters, and can therefore be usefully employed on mud floors smeared with cowdung. Ghadially suggests that cyanide of mercury added to the kerosene oil emulsion in sufficient quantity to make its strength 1 in 50 would be an ideal disinfectant for plague-infected houses.

It is perfectly reasonable to suppose that such a disinfectant possessing the combined properties of an insecticide as well as a germicide would not only be valuable in cases of plague, but also in cholera and typhoid fever cases, when we bear in mind the important part which flies play in the propagation

of the two latter diseases.

Dr. Sorab went on to point out that, owing to the nature of the bacilli in the body of a plague-sick animal such as the rat, or in the stomach of a rat-flea which has fed on such an animal, the most successful disinfectant would be such as is capable of destroying both rats

<sup>(</sup>a) Abstract of Paper read before the Indian Medical Congress at Bombay, February, 1909.

and their fleas. The fact that rats and fleas were generally to be found in situations inaccessible to the application of the disinfectants mentioned above materially handicaps the use of these substances. It therefore stood to reason that a gaseous disinfectant, alike poisonous to rats and fleas, and capable of penetrating into the inaccessible places frequented by these creatures, was the only one which offers some hope of success in combating the disease. A discussion of Clayton gas sulphur fumigation and formaldehyde gas and other disinfectants closed the paper.

# SPECIAL APPEAL.

## THE EARLY RECOGNITION OF UTERINE CANCER. (q)

AN APPEAL TO MEDICAL PRACTITIONERS TO PROMOTE THE EARLIER RECOGNITION OF ULTERINE CANCER.

THE attention of all Medical Practitioners is directed to the necessity of emphasising the curability by operation of uterine cancer in its early stages.

The adoption of a more extensive operation by the abdominal route has made it possible to deal successfully with cases hitherto regarded as inoperable, and to remove more of the pelvic cellular tissue as well as a portion of the vaginal walls; it is in these situations that recurrence is prone to develop.

Many patients now present themselves for examination and treatment when the disease is considerably advanced, and it is hoped that by a wide-spread and accurate knowledge of the early signs and symptoms

the number of such patients will gradually diminish. Special attention is directed to the following:—

- 1. Cancer of the uterus is at first a local disease,
- 2. Cancer of the uterus is often a curable disease.
- 3. Operation is the only satisfactory method of treatment.
- 4. The earlier the disease is recognised the more hopeful are the prospects of treatment.
- 5. The risk of operation in early cases is slight, and the chance of permanent cure is good.
- 6. The recognition of early cancer is not usually difficult, and the disease should not be overlooked by the medical attendant.
- A medical practitioner who fails to make a physical examination of the patient exhibiting any of the symptoms of uterine cancer incurs grave responsibility.
- 8. Treatment of symptoms without a physical examination is unjustifiable.
- Early cancerous ulcers should not be treated with caustic; their appearance becomes masked, and valuable time is lost.
- 10. It is an error to wait and observe in order to arrive at a diagnosis.
- II In doubtful cases a diagnosis must and can be made in a few days.
- 12. To examine, to diagnose, and then to treat, should be the rule in all cases.

Symptomatology.

Uterine cancer is at first a painless disease which does not affect the general nutrition.

The early symptoms of cancer are:—Irregular bleeding of any description, even if there be only traces; bleeding post coitum; and watery, blood-tinged discharge. There may be no loss of strength or wasting, nor any condition to alarm the patient. Pain, wasting, profuse bleeding, and foul discharge, indicate advanced disease

As the majority of cases occur between the fortieth and fiftieth year, the symptoms are too often regarded by the patient as due to "change of life." The medical attendant should not accept this assumption until he is satisfied that cancer does not exist.

(a) This appeal has been forwarded to us by the Editor of the Bri:. Med. Journ., in which journal it will also appear on the 15th inst.

Bleeding, however slight, occurring after the menopause, should give rise to the suspicion that cancer is present.

Examination.

If a patient with any of the above symptoms comes for advice, a careful visual and bi-manual examination must be made before any treatment is recommended.

Should a patient refuse to be examined—and this is exceptional when the situation is explained the medical attendant should decline any further responsibility, and no treatment should be advised. The examination should be made, even if bleeding is present, as valuable time may be lost by postponement until the hæmorrhage has ceased.

It is most important to observe rigid aseptic pre-

cautions in all manipulations.

In the examination, the condition of the vaginal portion of the cervix and of the cervical canal should

be carefully noted.

In the early stages new growth may be found on the surface of the vaginal portion of the cervix, in the lining of the cervical canal, or in the substance of the cervix. Any prominence on the surface of the vaginal portion or any ulceration, i.e., a definite loss of substance, should at once arouse suspicion. A nodule or nodules, hard, inelastic, or irregular in outline, felt in the substance of the cervix, suggest the presence of cancer. If the whole cervix be affected, the relative hardness as compared with the soft elastic body is pronounced.

The detection of high-lying cervical cancers, and cancers of the body of the uterus, is only possible

after curettage or digital exploration.

The signs common to the early stages of cancer of the cervix uteri are :-

- (1) The definite occurrence of new growth on the surface of the vaginal portion of the cervix in the lining of the cervical canal, or in the substance of the cervix;
- (2) Friability;

(3) Bleeding on manipulation.
(1) The definite occurrence of new growth on the portio vaginalis or in the cervical canal cannot fail to arouse suspicion. When, however, thickening of one lip or a portion of one lip of the cervix exists, the nature of the growth is difficult to determine if the mucous covering be still intact. It is then necessary to remove a portion of the affected tissue and examine it under the microscope.

(2) Friability is a sign of the greatest importance, and may be tested by the finger nail, curette, uterine sound, or an ordinary long probe. Degrees of friability exist in early cases, depending upon the amount of interstitial tissue contained in the growth.

(3) The occurrence of free bleeding after the slightest manipulation is, when combined with friability, a valuable diagnostic aid.

Forms of Uterine Cancer.

Vaginal portion of the cervix.

(1) Infiltrating type.—In this type, one lip, or a portion thereof, or even the entire vaginal portion of the cervix, is infiltrated with cancerous growth. Ulceration occurs early from the surface inwards, or necrosis may begin in the centre, and opening on the surface, lead to the formation of a deep ulcer,

with undermined edges.

The growth is somewhat hard in consistence, but is still friable if tested with the

- probe, curette, or finger nail.
  (2) Papillomatous or polypoid type.—This includes the so-called cauliflower excrescence, and is characterised by the growth from the margin of the os externum of a rounded or flattened tumour, varying in size, which may or may not have a definite stalk. It has a papillary surface, bleeds readily, and is very friable. More rarely it resembles a bunch of soft papillomata. Portions of the growth, pale red or greyish yellow in colour, are easily detachable on examination.
- (3) Superficial flattened type.—This is characterised

by a flattened growth on the vaginal portion which tends to spread over its surface. It is prone to early ulceration and is frequently seen clinically as an ulcer. The lip or portion affected is thickened. The ulcer has a sharply defined, raised edge, indented at places, yellowish grey, finely granular surface, a moderate amount of loss of substance, and an infiltrated base. bleeds readily on touch and the amount of hæmorrhage is entirely out of proportion to the amount of injury inflicted. The finger-nail can detach small pieces from its

The circumstances which led to the preparation of

this appeal are briefly as follows:

At the annual meeting of the British Medical Association at Exeter in 1907, the Section of Obstetrics and Gynæcology adoped a resolution requesting the Council of the Association to appoint a committee to consider the best means of disseminating knowledge of the importance of the early recognition of uterine cancer. That committee presented a report which was considered and generally approved by the same Section at the annual meeting of the British Medical Association in Sheffield in 1908.

Cervical Canal.

- (1) Superficial type.—The inner surface of the cervical canal is lined by an irregular papillary growth which at first attacks the substance of the cervix superficially. As the growth increases portions of it may protrude through the external orifice of the cervical canal. When ulceration occurs the superficial portions of the cervical canal. tion of the growth is shed, with consequent hollowing out of the cervical canal, whilst the remainder of the periphery of the cervix is more or less thickened by infiltration. Where the external os uteri is narrow the process may be hidden, or patency of the os uteri may be produced by destruction of its margin, whilst in uteri where the os
- is already wide a crater-like cavity is formed.
  (2) Infiltrating type.—The cancerous infiltration proceeds from the mucous membrane deep into the tissues of the cervix, and thus the whole cervix becomes thickened and enlarged, or the enlargement and infiltration may be limited to one or more portions of the cervical walls. Necrosis may commence on the mucous surface, or in the centre of the infiltrated area and may lead to extensive destruction of the cervical tissues.

Probably the majority of cancer cases which are overlooked are examples of disease affecting the lining of the cervical canal or the tissues of the wall of the cervix.

Cancer beginning in the cervical canal is not difficult to detect where the os uteri is dilated as in many multiparæ. The finger passed into the cervical canal feels irregular elevations or nodules from which portions may be removed. Free hæmorrhage follows Difficulty arises where the os this manipulation. uteri is not dilated and the disease is hidden. A sound carefully passed into the cervical canal may give the impression of impinging on an irregular nodular surface, or friable tissue may be removed by the curette. Free hæmorrhage following such manifestations is a suspicious sign. Thickening and hardening of the cervix may be detected by a rectal examination which is most helpful in detecting cancerous nodules in the cervical walls, and should always be made in such cases.

Body of the Uterus. 1

If the vaginal portion of the cervix, the cervical canal and the cervical walls have been proved to be free from disease attention must be directed to the body of the uterus. The uterus may not be enlarged, although a cancerous growth exists in its interior.

Usually, however, there is some increase in size, which in advanced cases may be considerable.

Microscopical Investigation.

In doubtful cases, if there be a suspicious hard nodule, or erosion, or ulcer on the external os uteri, a piece including a boundary of healthy tissue should be excised.

The vulva and vagina having been thoroughly cleansed, the posterior vaginal wall should be retracted by means of a speculum, and the cervix pulled slightly downwards with a volsellum. A wedge-shaped piece, the size of a pea or bean including a margin of healthy tissue should be excised with a sharp knife.

The bleeding which follows this little operation should be stilled by the insertion of one or two sutures,

or by firm tamponade with a strip of gauze. An anæsthetic is not essential. The patient should be kept in bed for 24 hours.

The tissue removed should be transferred to a small stoppered bottle filled with absolute alcohol or methylated spirit, and forwarded without delay to an expert

in uterine pathology.

Where the cancer originates in the body of the uterus or in the cervical canal, it is frequently possible by using the curette, to obtain a sufficient amount of tissue for examination without the aid of anæsthetics. If this cannot be done, it may be necessary under an anæsthetic to curette the whole interior of the uterus and cervix, special attention being paid to the region of the tubal orifices (a). All fragments should be collected, including those which may have been washed The douche, if employed, should consist of sterilised water or a weak solution of corrosive sublimate (1 in 10,000), as carbolic acid and lysol interfere with the staining of the cells.

The fragments should be transferred to a stoppered bottle filled with absolute alcohol or methylated spirit. If the expert's report is favourable the patient will be reassured, if unfavourable immediate operation is imperative.

The Operation.

The question of operation is best decided by the operator, who may require to examine under anæsthesia.

- To Recapitulate.
  (1) Attend to all symptoms suspicious of cancer, and instruct the patient on their importance; Examine immediately all cases of bleeding or
- abnormal discharge;
  (3) Make a definite diagnosis and do not wait for
- the disease to develop;
  (4) Urge immediate operation if the diagnosis is
- established.

The practitioner who diagnoses cancer in an early stage, when operation offers a probability of cure, renders a service to his patient as great as that rendered by the operator.

An Appeal to Midwives and Nurses in order to PROMOTE THE EARLY RECOGNITION OF CANCER IN THE WOMB.

Cancer of the Womb is a very common and fatal disease in women, but it can be cured by operation when it is recognised early. A woman sometimes tells a nurse or midwife her ailments before she speaks to a doctor, and the nurse or midwife has then an opportunity of aiding our crusade against this terrible disease.

Cancer may occur at any age, and in a woman who looks quite well and who may have no pain, no wasting, no foul discharge and no profuse bleeding.

To wait for pain, wasting, foul discharge, or profuse bleeding is to throw away the chance of successful

treatment.

The early signs of Cancer of the Womb are-

- 1. Bleeding, which occurs after the change of life.
- 2. Bleeding after sexual intercourse, or after a vaginal douche.
- 3. Bleeding, slight or abundant, even in young

<sup>(</sup>s) Special care should be taken in using the curette. as the ancerous uterus is easily perforated.

women, if occurring between the usual monthly periods, and especially when accompanied by a bad-smelling or watery bloodtinged discharge.

4. Thin watery discharge occurring at any age. The nurse or midwife who is told by a patient that she has any of these symptoms should insist upon her seeing a medical practitioner in order that an examination may be made without delay. By doing so she will often help to save a valuable life, and will bring credit to herself and to her calling.

# **OPERATING THEATRES.**

GUY'S HOSPITAL.

LAMINECTOMY FOR PAINFUL STUMP.-Mr. R. P. ROWLANDS operated on a man, æt. 50, who had been admitted suffering from intolerable pain in the stump of the left arm, the result of an amputation performed elsewhere about five years ago for compound fracture. At various times since several operations had been performed for painful stump. At the first the upper end of the humerus had been removed from the glenoid For the second the patient came under Mr. Rowlands' care at Guy's Hospital, when the neuromata were removed from the ends of the median, the ulnar, and the musculo-spiral nerves. This was not followed by success in relieving the pain. At the next operation, about a year and a half ago, the anterior primary divisions of the fifth, sixth, seventh and eighth cervical nerves, and of the first dorsal nerve, were exsected before they joined to form the brachial plexus. In this manner it was hoped to cure the pain, but, unfortunately, only temporary relief was obtained. man was a night watchman, but lately has had to give up his employment. He stated that he got very little sleep. He has much aged in appearance, and his hair has turned almost white during the last four years. He had threatened suicide on several occasions, having tried a variety of drugs in vain. Mr. Rowlands sent the patient to see Dr Hertz, who is in charge of the electrical department, with the view of the employment of electrical treatment, but the latter recom-mended the removal of the posterior roots ganglia.

The patient was anæsthetised and placed on his right side, with a sand pillow under his head. A large flap was taken up and turned inwards and downwards; the flap comprised all the muscles down to the semi-spinalis colli. The deeper muscles were peeled off the laminæ and retracted to the left. The deeper cervical vessels were secured at this stage of the operation. The laminæ and articular and transverse processes on the left side of the fourth, fifth, sixth and seventh cervical vertebræ and first dorsal vertebra were thoroughly exposed, and the laminæ were divided with Horsley's forceps close to the spinous and articular processes, portions of which were also removed. In this way the dura mater and the nerves were brought into view. The posterior root ganglia of the fifth, sixth, seventh and eighth cervical nerves, and first dorsal nerve, were drawn inwards, isolated, and removed. A good deal of bleeding occurred from the deep muscular vessels and the deep plexus of veins; a solution of adrenalin was poured into the wound with some advantage. This sent up the blood pressure and improved the pulse at a critical stage. (Dr. C. D. Edwards, who was making blood-pressure observations at the time, noticed that a great fall in the blood-pressure occurred after the escape of a considerable amount of cerebro-spinal fluid, which happened when one of the posterior root ganglia was being isolated. The operation lasted about an hour, and, owing to the great depth of the spinal canal in this patient (he was a big and rather stout man), the exposure of the ganglia presented many difficulties. At one time the pulse reached 170 per minute. A small gauze drain was placed in the wound, which was closed at all other

Mr. Rowlands pointed out that this severe operation seemed to be justified, for the following reason: The pain was so intolerable the man elected to run any risk in the hope of getting rid of it, and he had several times threatened to commit suicide. It was probable, Mr. Rowlands thought, that the cause of the pain was

an ascending neuritis following the original septic injury to the arm. This seemed to be confirmed by the entire failure of the several operations for painful stump. Granting this diagnosis to be correct, then the removal of the posterior roots ganglia should cure the pain, because the disease does not extend into the cord, which is itself insensitive. The experiments of Sherrington and others, pathological evidence, and the results of the removal of the Gasserian ganglion for trigeminal neuralgia, he said, seem to justify the The alternative diagnosis of functional neurosis had been well considered, but the man had been kept under observation in the hospital, and his insomnia proved to be genuine. It is, he remarked, unnecessary to remove more than half of each laminæ in such a case, and this moderation has the great advantage of not weakening the neck to anything like the same extent as complete removal of the selected laminæ and the spinous processes.

Ten days after the operation the stump is insensitive, but it is too early to say what the ultimate result of the operation will be. The shock soon reacted to treatment. The man had a great deal of headache for two or three days after the operation, due probably to loss of cerebro-spinal fluid, which continued to

drain away in small quantities.

# TRANSACTIONS OF SOCIETIES.

THE ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

MEETING HELD APRIL 30TH, 1909.

Dr. ARCHIBALD E. GARROD in the Chair.

FOURTEEN cases of Mongolian imbecility were exhibited.

Dr. G. A. SUTHERLAND showed three cases of this condition.

CASE I.-A male, æt.  $5\frac{3}{4}$ , an only child. The mother was 43 and the father 39 years of age at the time of his birth. There had been three miscarriages before patient's birth. He cut his first tooth at 12 months; learned to stand when 2 years old; walked and talked when 3 years old. He had never been cyanosed. The special physical characteristics were: A small head, small palpebral fissure with the axis sloping inwards and downwards, depressed bridge of the nose and epicanthus, the openings of the nares directed upwards, the mouth wide open, the tongue large, with some transverse fissuring, horizontal nystagmus and head shaking. The little finger and thumb were shortened, with slight curving of the former. There was no cardiac disease. Nasal obstruction had been pronounced until operation for adenoids had been done. The boy was very imitative, active, and required constant supervision. His habits were clean. Mental development was progressing, but was still very backward.

CASE 2.—Female, æt. 6. One other child in the family, æt. 12, is healthy. The mother was 40 and the father 39 years of age at the time of the patient's birth. The patient cut her first tooth at 13 months, began to stand and talk at the age of 3 years, and to walk at 3½ years. The abdomen was prominent, with an umbilical hernia. Head markedly brachycephalic and flattened antero-posteriorly; palpebral fissure small and sloping; nose not depressed; no epicanthus or nystagmus; tongue large; thumbs rather shortened; slight muscular hypotonus; no cardiac disease. She was active, imitative, and fond of music, and required constant supervision. Mental development was pro-

Case 3.—Male, æt. 4. One brother, æt. 18, and a sister, æt. 8, are both healthy. The patient could say simple words, and learned to walk at the age of  $2\frac{1}{2}$ years. He presented the typical features of Mongolian imbecility. The left hand showed also webbing of the third, fourth, and fifth digits. He was very fond of music, imitative and active. There was no evidence

of cardiac disease.

Dr. F. J. POYNTON showed four cases:-

CASE 1.—Female, æt. 4, a characteristic Mongol, was one of a considerable family, and was born when the mother was 40 years of age. There is a younger child who is healthy. The patient was brought to Great Ormond Street Hospital when aged 6 months, and since then had been treated with small repeated doses of thyroid. She talked when aged 2 years and 10 months, was passionate, fairly clean, and could say a few words, such as "pappa," "mamma," "more." Fond of musical sounds.

CASE 2.—Male, æt. 9, was the second child, the first and third children being normal. He had always been noticed to be backward. He took the bottle until set. 3, and for many months, instead of attempting to walk, and for many months, instead or attempting to walk, propelled himself about in tailor fashion, eventually walking between 3 and 4 years of age. He had been treated since September, 1908, with small doses of thyroid. The degree of intelligence was small. His aspect was of the usual type, and his manner characteristic was this ground the contraction. teristic of this group of cases. Since this treatment had been started friends and relations considered him "brighter," but it was difficult to discover any real improvement.

CASE 3.—Female, æt. 3, was the youngest of three children, being 7½ years younger than the next child. She was noticed to be "peculiar" at 3 months of age, and was unable to suck her bottle, but she cut her teeth at about the usual time. This case appeared to be of rather a milder type than some. She had been treated for over a year with thyroid, and during this time had made progress.

CASE 4.—Female, at. 4, had been treated since the age of 10 months with small continuous doses of thyroid. This characteristic Mongol was now beginning to talk, and was fairly clean. She did not appear to have made any real advance over other cases which had not had thyroid treatment.

Dr. FREDERICK LANGMEAD showed two cases.

CASE 1.-Male, aged 1 year and 7 months, was the only child of a young and healthy mother, æt. 26, who has not had any miscarriages. The facies was characteristic of the condition. Occipital development was more than usual in such cases. General growth was considerably delayed. The child sat up with difficulty, and could not properly support his head. Mentally he was cheerful and tractable, but had not made any attempt to speak beyond curious laryngeal noises. The little finger is not characteristically stunted nor incurved. Excluding an umbilical hernia and a prominent post-anal dimple, there were two associated malformations: (1) Congenital morbus cordis as evidenced by a loud systolic bruit, heard with greatest intensity at the inner end of the fourth left intercostal space, but also at the apex and along the left sternal margin; and (2) an accessory auricle on the right side. The cardiac condition caused some blueness at birth, and attacks of pallor and collapse during the first twelve months of life, but since then had not produced symptoms.

CASE 2.—Female, æt. 3, was the tenth of eleven children, three of whom died in early infancy. The youngest child was healthy. The aspect was children, three of whom died in early infancy. And youngest child was healthy. The aspect was characteristic of the condition, but the back of the head was not so flat as usual. There were grimacing and projection of the tongue, which was "granular" and projection of the tongue, which was granular from the enlargement of the papillæ and showed slight longitudinal fissuring. Growth was stunted, and development retarded. She made noises interpreted by the mother as "mum" and "dad." She was playful and mischievous, and showed her apprecia tion of music by moving her hands in time to a barrelorgan or piano. There was a congenital lesion of the heart, as shown by an increase of the cardiac dulness to the right and an evident but slight murmur in the pulmonary area. The heart malformat caused any symptoms or secondary signs, The heart malformation had not

Dr. LEONARD GUTHRIE showed two cases.

CASE 7.—A male, at. 5, in August, 1006 was admitted to the hospital for being dirty in his habits and bad-tempered. When examined he showed the usual Mongolian aspect, grimacing and gestures. He understood little that was said to him, and his speech was unintelligible except for a few words. He was extraordinarily imitative. After six months' stay in

the hospital he had considerably improved in intellect His habits were clean, and he was and manners. generally docile.

CASE 2.—A male, æt. 8, with signs of cretinism, who had improved under thyroid treatment. He was

first seen when 1½ years old.

Dr. MORLEY FLETCHER also showed three cases of Mongolian imbecility.

These cases were then discussed:
Dr. G. A. SUTHERLAND demonstrated the chief features of the condition, and said that the cause was still unknown. He did not think that any treatment, including that by thyroid did any good. Such patients were always lacking in vitality, and often died unexpectedly. Several died from 2 years onwards from tuberculosis.

Dr. POYNTON said that he had treated 12 cases for prolonged periods with thyroid, sometimes for over one year. He did not think that it had any specific action on the underlying constitutional deficiency. If this treatment were pressed, it was not well borne. Perhaps there were different grades of severity of the disease, some of which improved, whilst others did not. He had not seen more than two cases of asso-ciated congenital heart disease, and thought it inadvisable to operate upon the adenoids early.

Dr. LANGMEAD said that his first case was exceptional, in that he was the first-born of a young and healthy mother, æt. 26. Usually Mongolian imbeciles were born either at the end of large families or when the mother was getting towards the end of the child-bearing period. This was shown by his second case, where the child was the tenth and the mother 39 when it was born. Another point of interest shown by his first case was the associated malformations, i.e., a congenital heart lesion and accessory right auricle. second case was also the subject of congenital heart disease.

Dr. Morley Fletcher said that the characteristic flush on the cheeks did not occur until after the second year, and was preceded by a pallid, transparent skin. It was difficult to explain the blepharitis which was almost always present. He did not think that any deformity of the hand was characteristic. He had never seen any cases over puberty. Thyroid treatment had no effect except on the disposition.

Dr. Leonard Guthrie agreed that thyroid was useless in the ordinary cases. In his first case there were also signs of cretinism, and in such cases there were duced improvement. Both his cases were very imitative, but he thought that they always failed to profit

much by teaching.

Dr. SHUTTLEWORTH said that there was in the minds of the profession much confusion between Mongolism and cretinism. He was not so despondent as Dr. Guthrie about training, and could show several children, where the hands were being used with utility. They never became efficient workmen, but improved by imitation up to puberty, then came to a standstill, showing no power of originality. They were prone to tubercle, and usually died early, but lived longer in the better classes from among which Dr. Langdon the better classes, from among which Dr. Langdon Down had shown 14 cases, in ages ranging from 24 to 56. He had seen several cases of backward children who showed only a suggestion of Mongolism. With regard to the frequency of this condition, it constituted 5 per cent, of the defectives at the Royal Albert Asylum and 2.6 per cent. at Earlswood.

Mr. J. Jackson Clarke showed

SIX CASES OF CONGENITAL DISLOCATION OF THE HIP AFTER MANIPULATIVE OPERATION.

CASE 1.—Girl, æt. 6½ in August, 1903, when she was operated on for a right congenital dislocation, the diagnosis being confirmed by X-rays. When last seen. November, 1905, the result was a perfect restoration of the joint, the femoral head being in the acetabulum. The father wrote (February 27th, 1907): "She can

walk and run as well as any ordinary child."

Case 2.—Female, æt. 5½ when she was operated on for a left congenital dislocation (the diagnosis was confirmed by X-rays) on April 22nd, 1904. When last seen.

September, 1904, the joint appeared to be normal.

CASE 3.—Female, æt. 10 in May, 1904, when operated on for left congenital dislocation; diagnosis confirmed by X-rays. Owing to patient's age secondary changes

had occurred in the form of the bones, and after reduction a good deal of exercising was required to over-come stiffness. Eventually a true reduction with good function was obtained.

CASE 4.—Female, æt. 3 when operated on for right congenital dislocation; diagnosis confirmed by X-rays. A perfect result was obtained, the skiagram published in the British Medical Journal, 1905, ii, p. 784, showing an anatomical reduction.

Case 5.—Female, æt. 3 when operated on for a pro-nounced double dislocation, confirmed by X-rays. In

both joints a perfect anatomical result was obtained.

CASE 6.—Female, æt. 8 when operated on for a pronounced double dislocation (diagnosis confirmed by X-rays) in November, 1904. This patient, who was very delicate and had marked rickets, had been continuously under observation. One hip was anatomically and physiologically normal; the other was fimly lodged under the anterior superior iliac spine (anteverted) and had a good range of movement.

The above six cases were taken from the first consecutive and inclusive series of ten cases operated on from four-and-a-half to five-and-a-half years ago by the exhibitor. Of the remaining four one cannot be traced. She was shown before the Clinical Society as lately as April 28th, 1905, and she then walked well and the dislocated hip-joint that had been operated on, as seen in a skiagram shown at the meeting, was anatomically reduced. In short, the ten patients included in this series presented twelve congenital dis-locations. Of these nine are cured, one materially improved, and only two failed.

Mr. V. Warren Low also showed a case, in which

treatment had been very successful.

Mr. James Sherren showed a patient six years after

the performance of

OMENTOPEXY FOR ASCITES DUE TO CIRRHOSIS OF LIVER. Mrs. —, æt. 34, was admitted into the London Hospital in April, 1903. She had been confined three weeks before admission, and it had been noticed that her abdomen remained swollen. When seen about a week after her admission the abdomen was distended with fluid, the liver could just be felt below the costal marking and the spleen was markedly enlarged reachmargin, and the spleen was markedly enlarged, reaching nearly to the umbilicus.

At the operation on April 28th the abdomen was found to be filled with clear yellow fluid. The liver found to be filled with clear yellow fluid. The liver was firm and typical of the type of cirrhosis known as "alcoholic." There were a few adhesions of omentum to the enlarged spleen, which was firm; its capsule was thickened, and scattered over it were a few opaque-white patches. The parietal peritoneum was stripped from the posterior surfaces of both recti muscles and the omentum was stitched into the pockets thus made and between the edges of the muscles. A tube was inserted and the fluid drained for three weeks. The wound healed by first intention, and she left hospital free from

ascites and feeling well on May 27th.

She had been seen on several occasions since, and had remained free from symptoms. Two years after operation she bore a healthy child. The splenic enlargement had gradually diminished.

He had observed six other cases, but no permanent benefit had resulted in them. One had improved for

two years.

Mr. C. Gordon Watson said that several such cases had been operated upon at St. Bartholomew's Hospital, but that usually the result was a complete failure.
Dr. H. D. Rolleston said there was discrepancy

between statistics and personal experience. The difficulty lay in choosing suitable cases for operation before nutrition was impaired. His most successful case had lived one year and a month.

Dr. H. G. Turney showed a case of

TROPHŒDEMA FOLLOWING TRAUMA.

Male, at. 18. Six months ago he ran a nail into the inner border of his right foot and had not been able to work since. The slight injury soon healed, but ever since the accident the foot had been increased in

size. There had been no pain to speak of.

The condition was one of cedema of the right foot, which stopped abruptly at the ankle. The colour was normal; the skin dry and coarse, and the nails thickened. Movements were free and not painful. There was some general blunting of all forms of sensation (but particularly that of pain) not only over the foot but nearly up to the knee. The X-ray examination was negative. The coagulation-time of the blood was normal, and there were no varicose veins. There was no sugar or albumin in the urine. There was no sign of disease about the nervous system generally, except a well-marked vasomotor instability.
Dr. T. D. SAVILL and Dr. PHILIP GREEN showed a

SCLERODERMIA ASSOCIATED WITH ANGIONEUROTIC

GEDEMA.

Female, married, æt. 56. The skin of the hands, nose, forearms, and, to some extent, of the toes, was thickened and livid. There was no pitting on pressure. She could not use her hands to button her garments because of the mechanical difficulty of the mechanical diffi ments because of the mechanical difficulty of flexing and extending the joints. In the forearms the parts were becoming hidebound owing to the thickening of the skin and subcutaneous tissue. Over the left clavicle was an area of smooth, shiny, thinned skin, such as that left by morphea.

Her previous history was interesting.

bilious attacks, starting in the early thirties, about once a week. Alternating with these she had attacks of swelling on various parts of the surface of the body. Both the bilious attacks and the swellings ceased about two years ago, at the age of 54, when the hands first began to be persistently affected. The attacks of skin swellings had all the characters of angioneurotic œdema.

The family history was also interesting. Her mother died at the age of 54 of a sudden swelling of the face spreading to the throat, and causing death within twenty-four hours, which is suggestive in the patient's mind of the swellings from which she herself has sufdaughters. The second daughter, æt. 22, had had swellings in many different parts of the skin since the age of 12.

Dr. PARKES WEBER said that he had not considered Dr. Turney's case one of trophædema, but regarded it as a local infection producing chronic œdema, which he hoped would clear up. Dr. Savill's case had typical sclerodermia, which was well-known to produce chronic œdema; he thought the œdema in this case was analogous to the sclerodermia.

Dr. H. D. ROLLESTON did not regard the case shown as trophædema, for in that condition no thickening occurred. He had seen erythromelalgia follow trau-

matism.
Mr. C. Gordon Watson showed a case of DOUBLE INFANTILE COXA VARA TREATED BY SUBTRO-CHANTERIC OSTEOTOMY (WITH SKIAGRAMS).

Girl, then æt. 13, was admitted to the Metropolitan Hospital in December, 1907, with the history of deformity of hips and difficulty in walking since early childhood. There was no history of accident or illness. On admission she had a waddling gait, lordosis, and swung the body from side to side like a case of congenital dislocation. On examination of the hips the great trochanters were found to be greatly elevated. Abduction was practically abolished, but other movements at the hips were free, though limited. In dorsal decubitus the internal malleoli could only be separated Operation: December 10th, 1907-Tenotomy of adductores longi and other tense structures. December 17th, 1907—Double subtrochanteric osteotomy. On January 12th, 1908, a skiagram taken; left thigh accidentally refractured. January 20th, 1908, left thigh manipulated and put up again. At the present time (April, 1909), 16 months after operation, the legs can be abducted so that there is a distance of 36 in. between malleoli, and she walks well without waddling.

Mr. H. B. ROBINSON and Mr. W. H. Bowen showed

HEREDITARY TRANSMISSION OF CLAW HAND AND FOOT IN MOTHER AND CHILD.

Male, æt. 1, showed inherited claw foot. had a similar deformity of her feet, and in addition had deformed hands. The child's grandmother and great grandmother had similar deformities of the feet. A skiagram of the left foot showed the absence of the second metatarsal bone save for its proximal end. cleft in the foot corresponded to this bony deficiency.

The phalanges of the first metatarsal bone were present; those of the third and fourth bones were absent; and those of the fifth metatarsal bone were present, but the distal one of the two was turned outwards at right angles. The condition of the right foot was right angles. somewhat similar, but both the second and third metatarsal bones appeared to be absent, and the phalanges of the fifth metatarsal were not deflected. On the right side the great toe tended to point in an outward direction. In some of the cases of the deformity this outward deviation of the great toe was very pronounced, and tended to meet the inwardly deflected little toe produced the characteristic claw foot. The

family tree was exhibited.

Dr. A. M. Gossage said that the tree agreed well with the Mendelian law of heredity.

Dr. A. M. Gossage showed a case of COARCTATION OF THE AORTA.

Male, æt. 16, had always been rather short of breath, but had enjoyed fair health up to last October, when he was attacked with right facial paralysis from which he had since partially recovered. On examination there was some serious dyspnæa and marked pulsation of the carotids. The heart was hypertrophied, the radial pulse large, and with a sudden rise. There was pulsation and dulness in the second right interspace near the sternum. The superficial cardiac dulness came up to the fourth rib and to the right edge of the sternum. Systolic and diastolic murmurs could be heard over the aorta. Pulsation could not be felt in abdominal aorta, iliacs, or femorals. There was a small artery passing down on the right side of the epigastrium from the lower ribs to the umbilicus, and a small artery could also be felt in each axilla coursing down the sides of the thorax. Numerous small arteries passed at the back from the spine in the direction of the intercostal spaces under the skin. The aortic lesion was evidently congenital and probably in the usual position just above the junction of the ductus arteriosus with the aorta.

Mr. E. ARCHIBALD SMITH showed a case of

MULTIPLE CONCENITAL DEFORMITIES in a boy, 2 months old. The right tibia and left hip, and left patella were dislocated. The tibia was rotated outwards. There were extreme varus of the left ankle and umbilical and inguinal herniæ.

Mr. W. FEDDE FEDDEN read a paper on SIX CASES OF ACUTE INFECTIVE GANGRENE OF THE EXTREMITIES.

He said that apparently infective gangrene might be produced by a great variety of organisms—namely, the bacillus aerogenes capsulatus, bacillus coli, bacillus pyocyaneus, streptococcus pyogenes, and staphylococcus aureus. It was noteworthy that the bacillus of malignant cedema did not find a place in his series. The prognosis of cases due to bacillus aerogenes capsulatus was much more favourable than in those due to streptococcal infections, whilst those due to staphylococcus appeared to hold an intermediate position. The importance of early amputation was evident, and there was no time to wait for bacteriological data. should be our aim to amputate entirely through healthy tissue, but this was often impossible.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, APRIL 16TH, 1909.

The President, Dr. A. R. PARSONS, in the Chair.

CYSTS IN LIVER AND SPLEEN.

DR. PEACOCKE read a paper on cysts in liver and spleen, and gave some clinical particulars of the case from which the specimens exhibited were taken.

Professor Scott described the specimens. The liver was somewhat smaller than was usual, but the noticeable thing about it was the presence of half-a-dozen cysts spread around the margin, varying from one to two inches across. Each cyst was single. There was a single, somewhat small, cyst in the spleen. Sections under the microscopes showed numbers of flat cells. He believed they were not bile-cysts, but some form of lymphatic type.

SPLENO-MEDULLARY LEUKÆMIA.

Dr. ROWLETTE exhibited specimens of organs from a case of spleno-medullary leukæmia. The patient The patient was a woman, æt. 58. For many years she had been in good health, but had been treated once for some ondition of the heart. She was admitted to hospital in October last complaining of swelling of the feet. There was noticeable a very considerable swelling of the abdomen, and the whole of the left side was filled by a large tumour with a well-defined edge, reaching down to the left iliac region. Its greatest diameter was down to the left iliac region. Its greatest diameter was 16 inches. The blood was examined on October 18th, a fortnight after admission, and showed the red corpuscles to be 3,600,000, white cells numbered 040,000, and were of the usual type, except that one saw a larger number of "mast cells" than usual. The hæmoglobin was about 70 per cent. The condition of the blood left are doubt as to the diagnosis. tion of the blood left no doubt as to the diagnosis. The patient was treated with X-rays, and showed some Ine patient was treated with X-rays, and showed some improvement. In February an examination of the blood showed hæmoglobin about 80 per cent. The red corpuscles were considerably above the normal, and the white had fallen. The condition of the patient's heart was bad all the time, and she died in the beginning of March. The liver was very enlarged, and the heart had mitral disease, which was responsible in most part for the extreme passive congestion of the liver. The spleen was enormously congested. of the liver. The spleen was enormously congested. It was an interesting feature of the case that the red cells increased in number towards the end of life.

The PRESIDENT inquired as to the number of X-ray sittings, and as to whether there was any diminution of

the size of the spleen, or any change which might be attributed to the X-rays.

The Secretary said he had never seen a case of leukæmia with so little infiltration of the organs. more than one occasion he had the opportunity of testing the phagocytic power of the blood, and, while the influence of the serum in this regard appeared to be normal, he was forced to conclude that the phagocytic power of the polymorphonuclear leucocytes was considerably less than normal, and steadily lessened as the disease progressed.

Dr. Rowlette, in reply, said the patient was exposed to the X-rays about every second day, as a routine measure, from shortly after admission to hospital until shortly before her death. There was considerable diminution in the size of the spleen, but she was troubled with severe bleeding of the bowels, and the rays were suspended on a couple of occasions. He did not know that he could put down any definite condition to the rays. It was possible that the thickness of the capsule of the spleen might be attributable to

them, but he would not say so positively.

The Pathological Report of the Rotunda Hospital for the year 1908 was read, and the meeting adjourned.

# OPHTHALMOLOGICAL SUCIETY OF THE UNITED KINGDOM.

MEETING HELD AT THE ROOMS OF THE MEDICAL SOCIETY OF LONDON, THURSDAY, MAY 6TH, 1909.

The President, MR. R. MARCUS GUNN, F.R.C.S., in the Chair.

MAJOR R. H. ELLIOTT, I.M.S., exhibited instruments. (a) An evisceration spoon; (b) an optic nerve hook for use in the operation of optico-ciliary neurectomy; (c) an elevator for use in extirpation of the lacrymal sac.

Mr. Sydney Stephenson showed a case of congenital of patellæ, genu recurvatum, cryptorchidism, and other abnormalities.

Mr. G. WINFIELD ROLL showed a case with unusual appearance of the optic disc the result of a previous

Mr. E. TREACHER COLLINS showed a case of nodular leprosy affecting the eyes; also a case of progressive

bilateral ptosis.

Mr. HOLMES SPICER expressed the opinion that the condition was congenital, and thought the ptosis was closely allied to that in the cases of myasthenia gravis, which had been described.

Dr. G. CARPENTER read a paper entitled

A CLINICAL CONTRIBUTION TO THE STUDY OF TUBERCLE OF THE CHOROID.

The first patient, under Dr. Porter Parkinson, was vears of age. and had been getting thinner. Was 7 years of age, and had been getting thinner. admitted to hospital with physical signs at the right admitted to hospital with physical signs at the right apex, front and back. There was a history of abdominal pain, but no cause for it could be dis-covered by palpation. The child then became drowsy and comatose, with great wasting. There were six choroidal tubercles, and flecks of retinal pigment were scattered about them. Three of the tubercles were crossed by retinal vessels. A girl two years of age had been ailing six weeks, and had had sickness and headache five days. When admitted she was suffering from meningitis, and died on the sixth day. The right fundus was normal, and no tubercles or optic neuritis could be seen, but on the left side there was slight papillitis. Close to the optic papilla was a tubercle of considerable size, and several blood vessels crossed its face. The retinal arteries were small, nothing was noticed about the The surface vessels of the brain were con-The diagnosis was verified at the autopsy. gested. The next case was a boy, att. 17 months, who had much the same physical signs. He had meningitis, which was later corroborated by lumbar puncture. Another case was that of a boy, set. 2, who had had a bad cough five weeks, and when admitted had consolidation at both apices. There was a small amount of papillitis in both eyes. He died 12 days after admission, no changes having occurred in the fundus in the meantime. Several other cases of the kind were recorded, and the author then proceeded to discuss the readiness which had been shown to attribute such appearances to syphilis, whatever evidence to the contrary might have existed. He urged early and systematic ophthalmological examinations, which would often render unnecessary spinal punctures, or injections of substances to induce reactions.

The paper was discussed by the President and by Dr. Frederick E. Batten, the latter gentleman commenting on the comparative infrequency of tubercle of the chcroid in tuberculous children, and stating that he was under the impression that spinal puncture afforded a more certain indication than ophthalmo-

scopic observation.

Dr. CARPENTER replied.

Messrs. McKenzie Davidson and Arnold Lawson read a paper entitled a case of

SPRING CATARRH TREATED AND CURED BY RADIUM.

The patient was a boy, æt. 12, who suffered from chronic photophobia, lachrymation, and slight conjunctival discharge, which had persisted for nearly a year, but no exciting cause could be discovered. Both tarsi were covered with dense hard excrescences, closely aggregated, and separated by deep narrow fissures. The retro-tarsal tissue was swollen and hypertrophied, and the viscid discharge was spread over the conjunctival surface. The disease was confirmed by examination of the discharge. The irritability was chiefly marked in the morning. He was ordered complete cessation from close work, and was ordered complete cessation irrin close work, and dark glasses for out of doors. Yellow mercuric oxide was used, but no benefit resulted, and it caused too much pain. A week later he had cupric sulphate drops, of a strength of one to the ounce. In August the went to the seaside against his, Mr. Lawson's, advice, and got worse there. Bicarbonate of soda and hydrocyanic acid gave relief, and weak copper sulphate drops were used from time to time still. He then consulted with Mr. McKenzie Davidson as to the posconsider with Mr. McKenzie Davidson as to the pos-sibility of treating the case with radium. It was carried out for a year, during which period each eye was treated eight times. No pain or other immediate effect was produced, but the granulations gradually subsided. After the eighth application he was quite cured, but the interval before reading the communication was to make quite sure there had been no recurrence for a good time; 39 milligrammes of radium were used for 15 minutes at first, and then 44 milligrammes.

Mr. Lawson thought few applications with a potent dose of radium were better than many applications with a weaker quantity.

Mr. McKenzie Davidson discussed the case, pointing out the importance of being sure the strength of radium used was what it was said to be, as he had found serious discrepancies. It was also very important to cut off those radium emanations, which were not needed in the cure.

Mr. R. R. CRUISE read a paper on the ABUSE OF ATROPIN IN REFRACTION WORK.

The paper was based on the examination of 140 eyes in patients under 16 years of age. He concluded that, on the whole, homatropine and cocaine were quite equal, if not superior to, atropine, though in most cases the result after the two mydriatics was identical.

The paper was discussed by Mr. Stephenson, Mr. Bishop Harman, and Mr. Devereux Marshall, the latter of whom alluded to Mr. Lang's investigations on the matter; and Mr. Ernest Clarke said it would have been useful to learn what the astigmatism was in the cases.

Mr. Mayou read a communication on the disappearance of the iris from the pupillary area, following iniury.

# CORRESPONDENCE.

## FROM OUR SPECIAL CORRESPONDENTS ABROAD.

# FRANCE,

Paris, May 9th, 1909,

TAPPING FOR ASCITES.

GENERALLY speaking, ascites aggravates the condition of patients affected with this effusion in the abdominal cavity and constitutes a grave complication when the liquid is abundant.

It is thus that ever since the time of Hippocrates, the Father of Medicine, the operation of paracentesis has been practised, and generally to the great relief of the patient.

It must not, however, be forgotten that grave and sometimes mortal complications have followed para-centesis performed even under the most favourable conditions.

At the present day, the possibility of syncope a vacuo and acute peritoneal inflammation mentioned by older authors no longer exists, thanks to the use of fine trocars, antiseptic precautions and the position of the patient in the dorsal decubitus; but the possibility exists, and will always exist, says Dr. Perrin, of divers accidents, either immediate or consecutive. which it is well to know; even where the organic condition of the patient is the only responsible author, the reputation of the operator may be compromised. however unjustly.

These accidents may be grouped under five heads: serous anæmia, grave icterus, hæmorrhage of the abdominal wall, hæmorrhage of the digestive tract,

cardiac dilatation a vacuo.

It is customary to consider paracentesis as an insignificant and very simple operation, but as has been seen, in spite of all precautions, accidents are possible. Hence the necessity of the presiding surgeon to take measures against any avoidable accident.

Every patient for whom paracentesis becomes necessary, should have his heart examined and, if needs be, cardiac tonics should be prescribed several days before the operation.

A fine trocar should always be used, the patient placed in the horizontal position, and an abdominal bandage applied immediately after the operation.

The point of election for tapping is the junction of the middle and external third of a line drawn from the umbilicus to the iliac spine.

It is always prudent to inform one of the attendants that the operation does not always succeed, and to advise that in that particular case, a certain complication is possible.

VERTIGO.

In the course of chronic diseases, convalescence, and severe physical or mental strain, patients complain of vertigo, and this constitutes a very disagreeable symptom.

At the slightest effort, change of position or a simple emotion, they feel a loss of equilibrium, of obnubila-

Momentary vertigo rarely produces, however, a fall or loss of consciousness, yet it worries those who suffer from it.

Vertigo, a frequent symptom, proceeds from numerous and divers causes; cerebral and otic lesions, digestive troubles, cardiac and arterial affections, hepatic and renal insufficiency are frequent factors and require special treatment.

But the cases of vertigo already alluded to have another derivation, and are amenable to medication,

giving rapid results.

The majority of chronic maladies are accompanied by intense demineralisation of the whole organism. The physiological functions have not only to preside over the normal nutrition, but also to struggle against a condition of organic insufficiency. Under such conditions the waste of organic material affects an exaggerated rhythm, particularly as regards the constituent elements of the nervous system; these elements are: salts of soda, potash and magnesia. On these salts depends the function of the cerebro-spinal

In an organism exhausted by chronic disease, the demineralised nervous system, the cerebro-spinal axis, ill-nourished—become weakened and subject to slight functional intermittence, hence the same might be said of convalescence from acute diseases and

physical or mental strain. Án acute malady or muscular or intellectual fatigue, exhausts the mineral reserve of the organism. The nerve elements no longer find the quantity of soda, magnesia and potash necessary, and this mineral inanition shows itself by vertigo—a sensation of

emptiness in the head of intellectual impotence. It consequently behaves us to furnish the organism with the salts in question under the form of phosphate of soda, magnesia and potash, or as they may be found combined in a food preparation of the granular glycerophosphates, and under this treatment the disagreeable symptom of vertigo will rapidly disappear.

## EXTERNAL TUBERCULOSIS.

According to Dr. Calot, external tuberculosis may produce fatal results in three ways :-

(a) Amyloid degeneration of the liver or the kidneys, which causes nine-tenths of the deaths; it is due to the opening of the tuberculous abscess. A tuberculous abscess should never be opened. (b) Tuberculosis of the lung; avoided by keeping the patient as much as possible in the open air. (c) Meningitis, avoided by increasing the general resistance of the patient by procuring him absolute mental repose.

VOMITING

Stovain, 1 gr. Spirits of chloroform, 2 ozs. Peppermint water, 2 ozs. A tablespoonful every half hour. Acne of Young Girls. Resorcin, 15 grs. Lanolin, 6 drs. Olive oil, 2 drs.

# GERMANY.

Berlin, May 9th, 1909.

THE Deutsche Med. Zeitung, No. 34/09, has a reference to a paper on the INFLUENCE OF SALT ON THE COAGULATION OF THE

BLOOD. by Dr. C. Lichte. The following harmostatics are recognised: (1) Such as exert their action at the place of application, they are therefore entirely local; (2) such as exert an action at a distance.

The grouping may also be made in another way, the

hæmostatics being differentiated into the following, which act (a) by mechanical blocking of the vessel; (b) by contraction of the vessels (naturally the contraction must be general), or by contraction of the contractile tissue mass, in which the vessels implicated are situated; (c) by increasing the coagulability of the blood; (d) the so-called "aids" which indirectly obviate a long continued hæmorrhage (for example, hæmorrhage from the lungs which is obviated by the relief of cough by the derivatives of morphia)

Rarely has any hæmostatic any pronounced decided

action, independent of adrenalin.

Any effect is generally a combined one; for example, the vascular contraction and the mechanical blocking may be co-ordinated, or, one may follow the other, so that one effect brings up a supporting one, also (increase of the blood pressure, with local vascular contraction).

Those remedies with which the physician can exert action at a distance are of special importance. Gelatine gives the best distant effect. There is no longer any doubt of its efficiency, notwithstanding occasional

reports of failure.

Along with this, which has long been the object of scientific inquiry, is one the claims of which are equally high with that of gelatine, although its pharmacodynamics are so far unexplained. This old

folk remedy: common salt.

From the writer's personal investigations, he has drawn the following conclusions: there is a distinct drawn the following conclusions: there is a distinct raising of the coagulability of the blood after giving common salt, but only when the Na Cl is given in vivo, not in vitro. This effect, which is rarely absent when the blood is in a normal condition, appears after doses of 5 grm. of Na Cl, a small quantity in comparison with the usual therapeutic dose. Whether the effect of the dose is exhausted by the purely mechanical flooding as assumed by the writer, or whether a secondary positive catalytic effect is to be attributed to Na Cl or its ions in the individual phases of the act of coagulation cannot be said at present. The writer has also examined sodium bromide under conditions similar to those under which Na Cl was inquired into. The bromides are said to act as substitutes for salt, but not the iodides. The clinical experiences obtained by von Velden in the treatment of hæmoptysis by sodium bromide and Na Cl are in full agreement with those obtained experimentally by the author.

The same paper, No. 35, makes a reference to a

THE EXCITORS OF TRACHOMA,

by Prof. Greeff, Berlin.

He says they are regular round structures, distinctly smaller than the smallest known cocci. They are coloured intensively, sometimes a violet, sometimes a red after Giemsa, more feebly after aniline colours, not at all after Gram. They are surrounded by a clear yellow zone. With the highest powers it is sometimes seen distinctly that they are not a perfect globe, but somewhat oval, like bacteria with rounded edges. Where they are seen individually they show a tendency to divide into two, like diplococci. Trachoma granules must not be mistaken for eosinophile granules, as we see them in the leucocytes, which have not these properties. In later stages they lie together in large masses, the so-called "haufenform."

Halberstaedter and Prowaxek found the same

structures in trachomata in Java.

These structures only occur in trachoma; extensive control experiments had been made by others with negative results. Only quite fresh untreated cases need be examined for the structures. They lose their characteristic appearance very quickly after applica-tions with blue stone, even when there is no question of recovery. This is to be explained by the fact that the granules only disappear from the surface and are recruited from the deeper layers. They may be followed from the epithelium into the connective tissue, in threads often chainlike, the chains being reminiscent of streptococci. Both the writer and Leber had repeatedly seen them disseminated by white blood corpuscles.

# AUSTRIA.

## Vienna, May 9th, 1909.

## SUBFEBRILE TEMPERATURE IN TUBERCULOSIS.

At the Gesellschaft de Aerzte Engländer read a paper on the "Diagnostic Value and Therapy of Subfebrile Temperatures in Tuberculosis." He reminded the members of his method of taking temperatures from the urine which he introduced two years ago. During the last year he had employed that method in tubercular cases in Vienna and also in the Institution at Alland with the same result. In 75 cases he found 80 per cent. febrile or "high subfebrile." In suspected cases this temperature relationship was present; the "subfebrile" condition being an incontrovertible symptom in the case. In the Alland Institution he found cases where the temperature was normal in the armpit while the urine gave the "subfebrile" temperature. These parallel temperatures were present in 50 per cent. of the cases. He found also a very important symptom in these subfebrile temperatures, that if the patients were kept in bed they resumed the normal temperature in both urine and armpit. In most of these cases the most careful auscultation, percussion and radiography gave no manifestation of tuberculosis, hence the axillary temperature being perfectly normal and no other symptom of tuberculosis present, the case would be passed as one free from tubercle, but the urine temperature is a certain and safe guide in all doubtful cases.

Winternitz could not see the utility of this measuring of temperature in a funnel of filter paper in which a thermometer is placed. He thought the temperature of the anus and vagina, which were more accessible, would be more reliable than his urine method. With reference to the body temperature in the healthy, the temperature was not always found to be constant, as many causes were present to alter the reading, such as feeding. clothing, and rervous influences, which all had a varying effect on the temperature. The minimal morning temperature, which he has drawn attention to, we have always recognised as an early diagnostic sign of tuberculosis.

Weis remarked that in most of the phthisical cases an early temperature may be observed, but frequently this is not present in the first and second stages of the disease.

Engländer replied that by his own method, after all the symptoms and sputum had been carefully examined, this subfebrile sign was the most reliable in all suspected cases.

## LEIOMYOSARCOMA.

Paschkis next gave the history of a prostatic tumour which he had removed, whose microscopic structure proved to be a leiomyosarcoma, or Virchow's myoma lawicellulare.

## CEREBRAL GLIOMA.

Redlich exhibited a case which he had trepanned twice for epilepsy. The patient had the first fit about six years ago, after a heavy drinking bout, which repeated themselves at regular intervals. In the following year paresis in the right side set in, with congestion in both papillæ. A neoplasm was diagnosed in the motor centre of the left hemisphere, and as the attacks were becoming more frequent and severe, it was decided to operate in April, 1997. The trepannation revealed no morbid condition, and the wound was closed. After this the fits disappeared as well as the paralysis for a time. After a short interval the attacks began gradually to return in the form of Jackson's epilepsy, commencing in the right foot. Again the diagnosis of a tumour in the para-central lobe was made, with the result of a second operation, when an ill-defined glioma was discovered, and the greater portion of it removed. After healing, the right-sided paresis and epileptic fits have again returned.

Leischner said these were always very uncertain cases. In Eiselsberg's, in which he was engaged, 23 operations were performed for tumours in the brain, but only 18 were discovered, while 10 died immediately after the operation or during the healing of the wound. The results of the successful cases are also very discouraging and disappointing, as the disease recurs sooner or later, and the patient dies.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

## SCOTLAND.

THE LATE PRINCIPAL MARSHALL LANG, ABERDEEN .-The venerable Principal of the University of Aberdeen, the Very Rev. John Marshall Lang, D.D., LL.D., C.V.O., died in Aberdeen on May 2nd. He had been ill for about four months. His illness began with an attack of blood-poisoning, which led to a toxic anæmia, and though he rallied in so far as to be able to attend to pressing business, he relapsed somewhat suddenly towards the end. Dr. Lang was one of the leading clergymen of the Church of Scotland. He succeeded Norman Macleod in the Barony Parish, Glasgow, and was an ex-Moderator of the General Assembly. He was appointed Principal of the University of Aberdeen in 1900, at a time when the affairs of the University were not in a satisfactory state. The extension scheme, initiated by his predecessor, Sir William Duguid Geddes, was on foot, but had almost come to a standstill when half-completed for want of funds. Money was needed and a vast amount of work had to be done ere Dr. Lang's unwearied efforts were crowned with success. Dr. Lang's appointment was looked on by many as a rather dangerous experiment, and his reception by the students was far from friendly. Time, however, justified the selection of Lord Balfour. Principal Lang's administrative capacity, his impartiality, tact, and courtesy, and the dignity with which he supported his high office, soon won for him the esteem of the community. His conduct of the Quater Centenary celebrations in 1906, and the part he played in bringing the University extension to a successful issue (which was largely due to the way in which he enlisted the sympathies of the citizens of Aberdeen in the scheme) were recognised by his having conferred on him the Commandership of the Royal Victorian Order, the highest honour which usage permits a clergyman to receive. Dr. Lang was an orator; he responded willingly to all calls made on his services, and as well entered into the social life of the town. He is survived by a widow, one daughter, and six sons, one of whom has recently been elevated to the Archbishopric of York.

## BELFAST

PUBLIC HEALTH.—At the monthly meeting of the Belfast Corporation, held last week, the chairman of the Public Health Committee, Dr. King-Kerr, gave statistics showing a marked decrease in notifications of infectious diseases during the past month. The total number of cases notified was 20 per cent. under the previous month, and 65 per cent. under the same month last year. The decrease applied to all notifiable diseases except cerebro-spinal meningitis, of which five cases were notified during the month, as against two the previous month, and 13 in the corresponding period last year. There was, nevertheless, a distinct rise in the death-rate for the month, this being due to the influenza epidemic now prevailing. The meat and milk supply still gives a great deal of trouble in inspection, which it seems impossible to make efficient. It was reported at this meeting that milk is being regularly sold in Belfast from dairies which are never inspected. Trouble has arisen, too, over the inspection of pork. The pork butchers naturally complain of carcases being seized and destroyed when found unsound in their possession, while hundreds of carcases of pigs are arriving by rail every night, the inspection of which is merely perfunctory. It would seem that only a largely increased staft of inspectors could cope with the amount of work to be done.

INFLUENZA.—There is at present in Belfast a widespread epidemic of influenza, happily, on the whole, not very severe, though in some cases quite troublesome enough. Medical men seem to be having more than their fair share of it. At the opening of the summer session no less than four of the teachers in the medical school were incapacitated by attacks of it.

# LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

# "GENERAL PRACTITIONERS AND MIDWIVES."

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—Permit me in closing this correspondence to express regret that I have not made clear what I meant in my letters, and that as a result Dr. Ross has misunderstood me. I have the very highest regard for "the General Practitioner," and for his interests and welfare, and do not yield to anyone in that respect. When in 1879 I began the Zenana Medical Mission College, it was because I had seen for myself the terrible physical conditions of the natives in India, Africa and China, etc., and became alive to the untold bodily misery of the women and children. I advo-cated the shortened curriculum, so that those poor untended natives should have some trained and skilled ministrations. At that time there were no lady doctors, and none at all to give service to those in agony, for men doctors would not be allowed near them. We do not call the St. John Ambulance-trained who give their services, in the absence of any others, to those needing their help, "quacks." Nor can we apply the name to those women and men who give their help, in the absence of all others, to sufferers who have no one to show them pity, men and women often give their lives to seek to relieve the class of sufferers of whom I write.

By all means send out men and women with the highest qualifications, if you can get them. But what are they in number amongst the millions without anyone whatever to minister to them in their times of suffering and agony? Since I raised the standard of need of help for the bodies of those to whom the misneed of help for the bodies of those to whom the missionaries were sent, and for the missionaries themselves, their wives and children, many first-class medical men and women—with the highest qualifications—have come forward, and placed themselves in the foremost ranks of the fighting line.

I am, Sir, yours truly,
G. DE G. GRIFFITH.

London, May, 1909.

"EMPTY POCKETS."

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—It is easy to be virtuous on ten thousand a ear. It is easy to be oblivious of the seamy side of medical life if one is earning a net income of from £2,000 to £10,000 a year. It is, no doubt, difficult to think much about the poor practitioner struggling to make both ends meet, if one is absorbed in purely scientific work; and equally difficult to realise his misery if one fills one of the few appointments in the service of the Municipality or State open to the profession, which place their holders beyond the danger of poverty. Your editorial note this week under the heading of this letter, and the letter of "G. P." suggest these and other reflections. If the rank and file of the profession wish to improve their lot, they must set to work, combine, and help themselves. The men who ought to be the help and leaders of their less fortunate brethren are too much engaged in their own life-work to have time, or strength, for any thing else. The one organisation, the British Medical Association, which seems the right body to give voice to professional claims upon the State and the public, does virtually nothing. For this reason it is, perhaps, that it numbers less than half the men on the Medical Register. It does a little to promote science in the way of providing endowment for research, but, beyond this, service of the Municipality or State open to the proof providing endowment for research, but, beyond this, nearly all its resources and forces are engaged in supplying a weekly journal at a low cost to the members. The journal, which costs a truly stupendous sum to produce, is not read out of the profession, and notoriously has no political influence. It would be equally useful, so far as promotion of the welfare of the profession is concerned, if it were reduced to half its present size, and if the funds saved were applied in other more useful directions. Is it not possible to form from among the 20,000 who are not members of the Association, and from the many dissatisfied members

within it, a society entirely devoted to safeguarding and improving the material interests of the profession. This would not interfere with or check the progress of science. We are all working in this direction. Medical men are all helping to improve the health of the people, either by purely scientific research by which the prevention of disease is made possible, or by the teaching of hygiene and sanitation in their daily work. The profession has tremendous claims upon the public and the State; but there is no one to enforce these claims unless they will do it for themselves.

I am, Sir, yours truly,

AN OBSCURE PRACTITIONER.

May 6th, 1909.

# THE ADMINISTRATION OF ANÆSTHETICS. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The importance of the subject dealt with in your leading article of May 5th is so obvious that no apology is necessary for any attempt to place the matter in as clear a light as possible before the profession. In order to do so, there are two points which should be made quite clear. The first is the position of the so-called "quack dentist." This is really a most misleading title. Anyone who is not a registered medical or dental practitioner and yet practises the art of dentistry does so in defiance of the spirit, if not of the letter, of the law, and is liable to prosecution if he uses the title of dentist. The term "quack" is, no doubt, applicable to such an one, but the term dentist even with the qualifying prefix should not be used in his description. The use of such terms as "quack dentists" or "unregistered dentists" leads the public to suppose that those to whom it is applied occupy a recognised position, while in reality such is not the case. You further state in your article that the general medical and surgical training of the dentist is purely theoretical, and that they can have no scientific theoretical, and that they "can have no scientific knowledge of the effects of an anæsthetic, and no rules, other than rules of thumb, to guide them in their administrations." In the curriculum for dental students of the Royal College of Sur-geons in Ireland it is laid down that before qualification the dental student must not only quaincation the dental student must not only attend lectures in anatomy and physiology and pass examinations in these subjects, but he must also take out a special course of instruction in the administration of anæsthetics, and attend for twelve months the clinical practice of a general hospital. Furthermore, he must also pass a clinical examination in medicine and surgery. This being the case it would seem to us unfair that the dental student of the future should be and surgery. This being the case it would seem to us unfair that the dental student of the future should be deprived of the privilege, which the profession has so long enjoyed in the past, of administering anæsthetics to their patients. It should be also remembered that the most searching inquiries have failed to make out that the profession has in the past in any way abused this privilege. The number of deaths recorded as occurring during the administration of anæsthetics by qualified dentists compares, in every way, most favourably with the number recorded as occurring during the administration by medical men.

I am, Sir, yours truly,
T. PERCY C. KIRKPATRICK, M.D. Lower Baggot Street, Dublin, May 6th, 1909.

# OBITUARY.

DONALD RODERICK MORISON MURRAY, M.B., C.M.St.And.

WE regret to announce the death of Dr. D. R. Murray, one of the ablest practitioners in Leith. Dr. Murray, one or the ablest practitioners in Letti. Dr. Murray, who was in his sixtieth year, was born in Stornoway, and came to Edinburgh first as an Arts student, but subsequently entered Medicine. Thirty-two years ago he settled in Leith, where he built himself a large practice, and where for over twenty-five years he has been Admiralty surgeon and agent, with medical charge of the troops at Leith Fort, and the cavalry at Piershill on various occasions. Possessed of ability above the average, his skill as a practitioner made his name a household word in many circles, and

his vigorous personality, his genuineness, and his unfailing sympathy endeared him alike to patients and to friends, by whom his loss will be keenly felt.

GERALD FRANCIS YEO, M.D.Dub., F.R.C.S., F.R.S.

WE regret to record that the death of Dr. Gerald Francis Yeo, F.R.S., Emeritus Professor of Physiology at King's College, has taken place at his residence at Harbertonford, South Devon. Dr. Yeo was educated at Dungannon School and Trinity College, Dublin, and obtained the M.D. degree of Dublin University. He also qualified as a Fellow of the London College of Surgeons, and served as an Examiner in Physiology to the College, as well as to the Universities of London, Oxford, Cambridge, and the Royal College of Veterinary Surgeons. For fifteen years he was Honorary Secretary to the Physiological Society, and was elected a Fellow of the Royal Society in 1889. Dr. Yeo was born in Ireland in 1845.

# SPECIAL ARTICLES.

# THE POOR-LAW COMMISSION AND IRELAND.

THE Royal Commission on the Poor-laws and the Relief of Distress, which some time ago issued an exhaustive report dealing with the English portion of the inquiry, has now published its report on Ireland. There is, as in the case of England, a separate Minority Report, in which Prebendary Wakefield, Mr. F. Chandler, Mr. George Lansbury, and Mrs. Sydney Webb disagree with the Report of the Majority, and discuss the differences between the recommendations of the Majority and of the Viceregal Commission. To this Sir Henry Robinson and the Bishop of Ross, the Irish members of the Commission, append a rejoinder.
The following are the principal conclusions of the

Majority:—
That Boards of Guardians and general workhouses

be abolished.

That the County or County Borough be in future the area of administration and of charge for the relief of all classes of necessitous persons.

That the new local authority for the relief of the necessitous be known as the Public Assistance Authority and be a Statutory Committee of the County or County Borough Council.

Indoor Relief.—That we concur with the Vice-

regal Commission in recommending that there should be classification by institutions; that in each county the required number of the existing workhouses should be converted into specialised institutions for different

classes of inmates.

Medical Relief.—That the present dispensary medical service be a county service under the control of the Public Assistance Authority, and that the areas of the districts, where possible, be enlarged in view of

present population.

That County infirmaries, workhouse and other rateaided hospitals be co-ordinated, and that medical relief generally be under the management of the Public Assistance Authority, and that a County Ambulance system be established.

That a County Medical Superintendent Officer of Health be appointed, who shall also discharge the duties of Bacteriologist.

That Public Assistance Authorities have power to appoint nurses for nursing in the homes of the necessitous, in the same way as Boards of Guardians at present appoint midwives.

Outdoor Relief .- That outdoor relief be continued under proper safeguards and be chargeable over the whole area of the Public Assistance Authority.

Children.—That effective steps should be taken to secure that the maintenance of children in the workhouse be no longer recognised as a legitimate way of dealing with children.

The Aged and Infirm.—That the necessitous aged and infirm be accommodated in a number of specialised institutions, and preferably in small Homes or Alms Houses.

Lunatics, Idiots, etc.—That lunatics, idiots, and sane epileptics be maintained in asylums or institu-

tutions as recommended by the Viceregal Commission, and that disused workhouses be used as auxiliary

asylums for the purpose.

Unemployment.—That the existing provision for the relief of exceptional distress provided by Section 13 of the Local Government Act, 1898, is better adapted to the circumstances of Ireland than the Unemployed

Workman Act of 1905.

That the Unemployed Workman Act be discontinued.

The Minority of the Commission express dissent on several points, of which the following are the chief:-

The abolition not only of the Boards of Guardians, but also of all control by the elected representatives of the ratepayers over the public provision for the poor, and over the expenditure of the Poor Rate.

The establishment in each County and County

The establishment in each County and County Borough, of a new and wholly autonomous Poor-law body (under the name of "Public Assistance Authority"), on which the elected Councillors, of whom there need not necessarily be any at all, are expressly prevented from being in a majority.

In opposition to the proposals of the Viceregal Commission for the complete separation from the Poor-law of the whole transfer of the side it is now.

commission for the complete separation from the Poor-law of the whole treatment of the sick, it is now recommended that the whole Public Health service, including the County Bacteriologist, and all the County Infirmaries and Fever Hospitals, together with the Dispensaries, should become a Poor-law function; that the sick poor now under the County and County Borough Councils should become paupers; that the control of these County Infirmaries and Fever Hoscontrol of these County liminates and rever hos-pitals should be taken away from the County and Caunty Borough Councils, and handed over to the non-elective "Public Assistance Authorities" already described; and that the public treatment of tubercu-losis should be equally a matter for the Poor-law, and the Poor-law alone.

We entirely agree, too, with the recommendation of the Viceregal Commission that the treatment of the sick should be wholly removed from the relief of other classes, and should be entirely dissociated from pauperism. The English Poor-law and the Workhouse System, unhappily forced upon Ireland in 1838, have remained alien and abhorred. Ireland, even more for the policy of "Break up the Poor-law and abolish the Workhouse." In our judgment any attempt to set up a new Poor-law, and a new Poor-law Authority under whatever name—would be a repetition of the

mistake of 1838.

# THE PROPOSED DUTIES ON PETROL AND ON MOTOR CARS.

THERE are so many medical users of motor cars at the present time that a short statement of the probable effect of Mr. Lloyd George's new duties on motor cars and on petrol will be of interest.

In the first place the following scale of taxation

has

peen	propo	<b>SCU</b>					
Cars	under	61	h.p.	 ٠.	£2	2	О
,,			h.p.	 	3	3	О
,,		16	h.p.	 	4	4	О
,,	,,	26	h.p.	 • •	6		0
,,	,,	33	h.p.	 	8	8	О
,,			h.p.	 	10	10	0
,,	,,		h.p.	 	2 I	0	О
"	over			 	42	0	0

Medical men will obtain a rebate of 50 per cent. from this scale and, in the case of those who live in Great Britain, it is probable that this will in some cases mean a reduction of the present duty. On the other hand, at the present time there is no duty on cars in Ireland, and, consequently, whatever tax is now fixed is all so much direct increase in the case of Irish users. The horse-power will be calculated on the bore and number of the cylinders, as is done by the "Royal Automobile Club formula," and the length of the stroke of the piston-rod will not be taken into account. One consequence of this will doubtless be that the length of the stroke will be increased by the makers of cars to the utmost consistent with smooth running.

In the second place, a tax of three pence per gallon

has been proposed on all petrol used in motor cars. The amount which each car owner will pay under this head will, of course, vary according to the amount he uses his car and to its size. Assuming that a medical man runs five thousand miles in the course of a year, and his car averages twenty miles to the gallon of petrol, the annual loss by this tax will be £3 2s. 6d. This, however, is not all. The tax is to be collected from the importers of petrol, and as these gentlemen consider that they will be put to extra expense by having to comply with the requirements of the Inland Revenue, they have increased the price of petrol not by three pence but by four pence. This will mean a total increase in the price of the petrol used under the conditions mentioned above to £4 3s. 4d. If to this is added £1 10s. duty, the total extra cost of a small car for a medical man will come to £5 13s. 4d.

We have referred elsewhere to the necessity of

We have referred elsewhere to the necessity of medical men combining with the object of compelling Mr. Lloyd George to give them the same rebate as is given to other "commercial" users of petrol.

# MILITARY & NAVAL MEDICAL NOTES.

HIS EXCELLENCY THE GOVERNOR OF GIBRALTAR has appointed Major H. A. L. Howell, R.A.M.C., Medical Officer of Health during the temporary absence of Major C. E. P. Fowler, R.A.M.C., who is Medical Officer to the British Mission proceeding from Tangier to Fez to meet the Sultan of Morocco.

ARMY Medical Officers should, if possible, read a part of the book recently translated by Colonel Corvisart (formerly French Attaché at the Japanese Court), viz., "The Regulations of 14th October, 1907, on Field Service in the Japanese Army." These regulations replace those of February, 1900. The chapters on food, hygiene, and medical care will be found instructive, and the instructions in regard of obtaining "intelligence" extend to strictly questioning abandoned sick and wounded. The Japanese seem to have nothing to learn from European nations in the matter of their medical arrangements.

The following remarks on retired pay appear in the Army and Navy Gazette: Colonel H. Charlesworth, C.M.G., retired pay, R.A.M.C., who is now Senior Medical Officer Recruiting, St. George's Barracks, and whose services in the London district cease on 30th April, has been offered and has accepted Nottingham, where for some time past the recruiting work has been done by a civilian. The Director-General is being, as far as possible, most considerate to the retired medical officers in London who are to be replaced by full pay officers, by offering the former other vacancies where mostly civilians have been employed. It has been found that civilian employment is not quite so economical as that of retired pay officers, for we hear of some stations where the former draw as much as \$\( \)300 a year, while a retired medical officer could be similarly employed for \$\( \)150 per annum, just half the money. We understand that Sheffield is an example in point.

An important letter on "Medical Etiquette" appears in *The Pioneer Mail* (published at Allahabad, India). It bears the pseudonym of "Husband." It clearly indicates that medical officers in India are not as careful as they should be about disclosing and discussing the ailments of their patients. In a country like India, above all others, where gossip and curiosity are rife, there is the more need for a rigid secrecy such as has to be exercised by lawyers and priests.

SECUNDREABAD, in the Deccan, India, is a station where enteric fever is always more or less prevalent. Last month (March) Lieut.-Colonel Butt, the Senior

Medical Officer, was endeavouring to discover the cause of the prevalence of this disease in the station. He made a series of surprise visits to coffee shops, Army Temperance Association spots, and Soldiers' Home, the kitchen of which was closed for a week. Meantime a circular was issued warning the troops against bread and pastry turned out by a certain bakery, which has been ordered to be closed.

THE "Indian Subordinate Medical Department" is apparently smarting under the designation of their corps if we may judge from a long letter which appears in *The Pioneer Mail*, of 2nd April. The writer proposes that the rank and designation of the corps should be "Assistant Surgeon, Indian Medical Department," wishing the word "subordinate" to disappear. In like manner he says the title "honorary" lieutenant or captain should go by the board.

# REVIEWS OF BOOKS.

AIDS TO MEDICINE. (a)

This little book forms one of the well-known "Aids Series," published by Messrs. Bailliere, Tindall and Cox. The necessarily condensed nature of its information may be gathered from the fact that the bird's-eye view of contemporary modern medicine has been condensed into a compass somewhat short of 250 pages of small octavo. The previous edition was issued in four small volumes about the size of the present one, but it was found that this form was not full enough for a text-book, but too large for the purpose designed by the "Aids Series." Hence the revision and condensation into one volume. In its revised form it will be found a most useful and trustworthy companion when used in the right way. It is not, of course, intended to replace the larger text-books and manuals, but as a means of refreshing the memory as to the salient points of a subject that covers an immense and an ever-increasing extent of ground, we can imagine no more convenient outline map and guide-post, as it were, for the harassed student or the busy practitioner. In a short notice it is, of course, out of the question to enter into anything like a detailed criticism of the contents of a work like that under review. We shall content ourselves with saying that we have carefully read several sections of the book, and are satisfied with the accuracy of the statements. This would be expected from an author having Dr. Hudson's experience of hospital practice.

SURGERY: ITS PRINCIPLES AND PRACTICE. (b)

The fourth volume of Keen's well-known work deals more with special subjects than did any of its predecessors. The subjects discussed fall more or less into well-recognised groups, although the order in which they are treated does not correspond with such a division. Generally speaking these groups are:— Intestinal surgery, genito-urinary surgery, surgery of the ear, surgery of the eye, and, finally, naval, military and tropical surgery. There are fifteen chapters in all, and amongst the different contributors we notice the names of Drs. Bevan, Coley, de Schweinitz, Murphy, Rodman, Young, the Surgeon-General of the United States Army, and the Surgeon-General of the United States Navy. The list is a very representative one, though perhaps some of the contributors are not so well-known over here as were those to the former volumes.

The chapters on genito-urinary surgery occupy

<sup>(4) &</sup>quot;Aids to Medicine." By Bernard Hudson, M.D.Cantab..
M.R.C.P.Lond., Assistant Physician. City Road Hospital for Diseases
of the Chest, &c., &c. London: Bailliere, Tindall and Cox. 1909.

<sup>(</sup>b) "Surgery: its Principles and Practice, by various Authors." Edited by William W. Keen, M.D., LL.D., Emeritus Professor of Surgery and of Clinical Surgery, Jefferson Medical College, and John C. Da Costa, M.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Vol. IV. Pp. 1194, with 582 illustrations. Philadelphia: W. B. Saunders Company. 1908.

nearly half the book and deal in a most comprehensive manner with their subject. One chapter deals with the examination of the urine in relation to surgical measures, and surgeons would profit greatly by paying close attention to its advice. Chapters on the surgery of the kidney, ureter and suprarenal gland, of the bladder, of the prostate and the penis and urethra, and of the scrotum and testicles follow. Cystoscopic methods are clearly described, and the different forms of cystoscope are shown.

The chapters on intestinal surgery will also repay close study. They are written by Abbé, Van Hook, Kanavel, and Murphy.

The chapters on ear and eye surgery are very full, and constitute in themselves almost a monograph on the subject.

aph on the subject.
The chapters on naval and military surgery are
ide in their scope and of extreme interest. The wide in their scope and of extreme interest. chapter on military surgery discusses seriatim such subjects as organisation and administration, personnel, field hospitals, the medical department in the field, and the treatment of wounds in war. The chapter on naval surgery deals with battleship conditions of the present day, the medical department and preparation for battle, conduct of the medical department during battle, surgical conditions of naval warfare, conduct after battle, and hospital ships. It also contains some striking illustrations of wounds received during warfare.

We congratulate the editors and contributors on the excellence of the present volume.

# MEDICAL NEWS IN BRIEF.

## Child Study

PROFESSOR J. A. GREEN, of Sheffield, read a paper on "The Study of Types in the Mental Life of Children" at the Child Study Society Conference at Manchester University on the 8th inst. Professor Green said we had been told from time immemorial that we should respect the individuality of children. But it was idle to ask the teacher responsible for sixty children to have very much care for individuality in pupils. He referred sarcastically to the education theorists who maintained that the child in the course of its mental development recapitulated the history of the race. He thought the unfortunate part of such a method was that it started with a theory and looked for confirmation. The child mind was so delightfully complex, presenting so many facts to the observer, that nothing was easier than to find evidence of a theory of this kind. On the basis of this method the evident fear and recoil of the child when some grown-up person threatened "I'll eat you," indicated clearly a once cannibalistic period in the history of the race.

## Royal College of Surgeons in Ireland,

AT a meeting of the Council held on Tuesday, the

At a neeting of the Council held on Tuesday, the 4th of May, 1909, the following Examiners were elected for the ensuing year:—
Court "A."—For Conjoint License, Diploma in Public Health, and Preliminary.—Anatomy: Alexander Fraser, F.R.C.S.; Bertram G. A. Windle, B.S., Univ. Dub. Surgery: Charles A. K. Ball, F.R.C.S.; Alexander Blaney, F.R.C.S.; F. Conway. Dwyer, F.R.C.S.; Robert J. Harvey, F.R.C.S. Physiology and Histology: Denis J. Coffey, B.S., R.U.I.; E. L'Estrange Ledwich, L.R.C.S. Pathology and Bacteriology: Arthur Hamilton White, L.R.C.S. R.U.I.; E. L'Estrange Ledwich, L.R.C.S. Pathology and Bacteriology: Arthur Hamilton White, L.R.C.S. Midwifery and Gynæcology: Frederic W. Kidd, L.R.C.S. Biology: John J. Burgess, F.R.C.S. Ophthalmclogy: Arthur H. Benson, F.R.C.S.; Herbert H. B. Cunningham, F.R.C.S.; Herbert C. Mooney, F.R.C.S. Sanitary Law and Vital Statistics: Matthew J. Russell, F.R.C.S., D.P.H. Engineering and Architecture: James H. Fergusson, F.R.C.S., D.P.H. Mathematics, Physics, Dictation, and English Fessay: I. W. Tristram, M.A., Dub, Univ.

Essay: J. W. Tristram, M.A., Dub. Univ.
Court "B."—Fellowship, License in Surgery (for
Registered Practitioners), License in Midwifery (for
Registered Practitioners), and License in Dental

Surgery.—Anatomy: Alexander Fraser, F.R.C.S.; Edward P. McLoughlin, B.Ch. Surgery: Charles A. K. Ball, F.R.C.S.; Alexander Blaney, F.R.C.S.; F. Conway-Dwyer, F.R.C.S.; Leveson G. Gunn, F.R.C.S. Physiology and Histology: Denis J. Coffey, B.S., R.U.I.; E. L'Estrange Ledwich, L.R.C.S. Pathology and Bacteriology: Robert J. Rowlette, M.D., Dub. Univ.; Arthur Hamilton White, L.R.C.S. Midwifery and Gynæcology: Frederic W. Kidd, L.R.C.S. Chemistry and Physics: Edwin Lapper, F.R.C.P.; Robert J. Montgomery, F.R.C.S. Dental Surgery and Pathology: George M. P. Murray, F.R.C.S.; William G. Story, L.D.S. In Mechanical Dentistry: Daniel L. Rogers, L.D.S.; Edward L. Sheridan, L.D.S. Surgery.—Anatomy: Alexander Fraser, F.R.C.S.;

## Middlesex Hospital-Founder's Day.

THE Annual Middlesex Hospital Founder's Day Commemoration Service will be held in the hospital chapel on Wednesday, May 19th, at 3.30 p.m., when a sermon will be preached by the Rev. Herbert E. Guason, M.A., the chaplain. After the service visitors will have the opportunity of inspecting the wards of the hospital, and will be entertained at tea by the invitation of Lord Cheylesmore and members of the Weekly Board of Governors, in whose name the cards of invitation are issued.

# Midwives Act Committee.

THE eleventh meeting of the Departmental Committee appointed by the Lord President of the Council to consider the working of the Midwives Act was held at the Privy Council offices on May 5th, Mr. Almeric W. FitzRoy, Clerk of the Council, presiding. Evidence was tendered on behalf of the British Medical Association by the following witnesses:—Mr. J. Smith Whitaker, M.R.C.S., L.R.C.P., Medical Secretary of the Association; Mr. C. E. S. Fleming, M.R.C.S., L.R.C.P., Bradford-on-Avon; Dr. L. S. McManus, Wandsworth; and Mr. J. H. Taylor, M.B., Salford.

# Apothecarles' Hall, Dublin.

THE following candidates have passed the quarterly examinations of the Apothecaries' Hall, Dublin:—

First Professional.—In Biology: Simon Carroll, Joseph A. Moloney, George M. Mayberry, Bernard J. M. Neary, Michael O'Donnell. In Physics: Michael O'Donnell. In Chemistry: Bernard J. M. Neary, Completed Examination: George M. Mayberry, Bernard J. M. Neary, Michael O'Donnell.

Second Professional.—In Physiology and Histology: George M. Mayberry.

Second Professional.—In Physiology and Histology: George M. Mayberry.
Third Professional.—In Pharmacy: Edward Murphy, Jeremiah J. O'Mullane, George Andeen.
In Pathology: Jeremiah J. O'Mullane. In Medical Jurisprudence and Hygiene: Jeremiah J. O'Mullane.
Completed Examination: Edward Murphy, Jeremiah J. O'Mullane. J. O'Mullane, George Andeen.

J. O'Mullane, George Andeen.

Final Professional.—In Medicine: George Andeen,
Jeremiah J. O'Mullane. In Surgery: Jeremiah J.
O'Mullane, George H. Fisher, James H. Nichol,
James Stuart. In Ophthalmology: Jeremiah J.
O'Mullane, James H. Nichol, James Stuart. In
Midwifery and Gynæcology: George Andeen, S. E.
David, Edward Murphy, Jeremiah J. O'Mullane.
Completed Examination: George H. Fisher, Jeremiah
J. O'Mullane, James H. Nichol, S. E. David.

## Conjoint Examinations in Ireland.

THE following candidates have passed the Third Professional Examination of the Royal College of Physicians and the Royal College of Surgeons, April, Physicians and the Royal College of Surgeons, April, 1999;—C. E. Drennan, M. Drummond, R. A. W. Ford, G. J. Fraser, J. Gormley, P. Grace, F. J. Graham, L. A. Moran, H. H. Montgomery, J. McMullin, T. B. Newman, R. O'Connor, M. A. O'Callaghan, W. Rahily, A. A. Russo, H. C. Smyth, T. M. Thomson, F. W. Warren, R. H. Weir.

THE Chemists' Exhibition of this year is in full swing at the Royal Horticultural Hall, Vincent Square, Westminster. Medical visitors will find much practical interest in the exhibition, which is always replete with the latest novelties in pharmacy and allied matters. The exhibition week closes on May 14th.

# **NOTICES TO** CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

SUBSCRIPTIONS.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), &s. 6d. per insertion; 6d. per line beyond.

6d. Per line beyond.

Zenana.—Your views upon measles are shared by a great and increasing number of persons, both lay and medical in Liverpool last week it was pointed out, in a report of the Health Committee, that a quarter of the total number of deaths were due to measles, and one of the aldermen suggested that a special municipal research should be instituted with a view of finding a remedy for the disease. One of the great obstacles is the deep-rooted belief that measles is inevitable, and that it is a malady of little moment.

A GOOD YEAR'S WORK.

The annual statement of the Chairman of the Metropolitan Asylums Board last week showed that there had been no failing off either in amount or in efficiency of the excellent ambulance work of that body. During the year the removals numbered 59,870, with a mileage of 421,594 miles, and the record of entire freedom from accident involving injury to patients had been maintained. The use of motor omnibuses proved successful and economical.

economical.

J. H. Maclea.—A diet chiefly composed of tea, bread and cheese is certainly not calculated to encourage a strong and enduring race. It will be a bad day for Scotland should its country workers abandon their porridge. Milk, bacon and butter or lard added to bread and cheese would form a good basis—and tea in moderation is, of course, preferable to alcohol. The baked beans which form so important an article of diet with the American rural population might with great advantage be introduced to the United Kingdom. Baked beans are now being largely imported in tins, and are of excellent flavour and quality.

# Meetings of the Socielies, Tectures, &c.

Miletings of the Societies, Technics, &c.

Wenderday, May 127H.

United Services Medical Society (Royal Army Medical College Millbank, S.W.).—8.30 p.m., Major H. W. Grattan, R.A.M.C., and Captain D. O. Hyde, R.A.M.C.; Some Points in the Standardisation of Typhoid Vaccine, North-East London Post-Graduate College (Prince of Wales's General Hospital, Tettenham, N.).—Clinics: 2.30 p.m.; Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

Thursday, May 137H.

Royal Society of Medicine (Obstetratical and Gynrechaolcal Section) (20 Hanover Square, W.).—7.45 p.m.; Short Communication: Mr. J. Bland-Sutton: Red Degeneration of a Uterine Fibroid, Associated with the Staphylococcus Pyogenes Aureus. Specimens: Specimens of Ruptured Uteri will be shown by the President, Dr. W. E. Fothergill, Dr. H. Russell Andrews, Dr. J. B. Hellier, and others. Papers: Dr. T. W. Eden: The Operative Treatment of Rupture of the Uterus; with an Account of Three Cases treated by Abdominal Hysterectomy. Dr. Lionel Smith: The Treatment of Rupture of the Uterus; with a Description of Casee.

Harveian Society of London (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m.; Dr. H. J. Macevoy: Paroxysmal Pulmonary (Edema in Bright's Disease. Dr. B. H. Syllsbury: Some Practical Points in Clinical Bacteriology.

Medical Chaddats' College and Policlinic (22 Chemies Street, W.C.).—4 p.m.; Sir Jonathan Hutchinson: Clinique (Surgical, 5.15 p.m.; Lecture: Dr. F. J. Wethered: The Treatment of Chronic Heart Disease, especially by Mechanical Methods.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynrecological Operations (Dr. A. E. Glies). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson): X-Bays. 5 p.m.; Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Feidar, Mar 147E.

ROYAL Society of Medicine (Clinical Esection) (20 Hanover Square, W.).—8 p.m.: Cases: Dr. F. Spioer: Paralysis of Spinal Accessory Nerve. Mr. W. G. Spene

A Patient with Sprengel's Deformity of the Shoulder and Hirschsprung's Disease (Definite Rectal Obstruction). Dr. McNaity: Aortio Aneurysm (?) in a Boy. Dr. Parkes Weber: Woman Three Years after Omentopexy and Drainage for Chronic Ascites probably connected with Hepatic Cirrhosis. Dr. F. de Havilland Hall and Mr. W. G. Spencer: Spleneotomy for Splenic Ansemia. 9 p.m.: Dr. T. Stacey Wilson will show Three Coloured Projection Drawings of the Brain, showing the Relations which the Internal Structures would be seen to have to the Convolutions if the Brain were Transparent. 9.45 p.m.: Paper: Dr. Poynton and Mr. Trotter: A Case of Cardiolysis with a resumé of the Operative Measure Practised.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chemies Street, W.C.).—4 p.m.: Dr. S. Spicer: Clinique (Ear, Nose, and Throat).

CENTRAL LONDON THEOAT AND EAR HOSFITAL (Gray's Inn

CENTRAL LONDON THEOAT AND EAR HOSPITAL (Gray'S Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. D. McKenzie: External Ear.

# Appointments.

BEVIR, GEORGE, L.R.C.P.Lond., M.R.C.S., pro tem. Medical Officer for the Timsbury District by the Clutton (Somerset) Board of Guardians.

DOWDING, E. F. C., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the King's Cliffe District of the county of Northampton.

PRITCHETT, GEORGE WILLIAM MORBIS, L.R.C.P.Lond., M.R.C.S., District Medical Officer by the Liskeard (Cornwall) Board of Guardians

Guardians.

GHARTHAN ALFRED, M.B., Ch.B.Edin., District Medical Officer by the Newton and Llandiloes (Montgomeryshire) Board of

the Newton and Linsualized Guardians.

SHINGLETON-SMITH, LIONEL, M.B., B.C.Cantab., L.R.C.P.Lond., M.R.C.S., Medical Officer to the Brecknock Union (Brecon) Workhouse.

SHORTEN, W. J., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Duncannon District of the county of Waterford.

# Bacancies.

Children's Hospital Dublin.—House Surgeon. Salary, at the rate of 50 guineas per annum and extras. Immediate application to Hon. Secretary, Medical Board. (See advt.)

Brighton, Hove, and Preston Dispensary.—House Surgeon. Salary, 2130 per annum, with board and residence. Applications to the Assistant Secretary, 113 Queen's Road, Brighton.

National Hospital for the Paralysed and Epileptic, Queen Square. Bloomsbury, London, W.C.—Senior Dispenser. Salary, 2150 per annum. Applications to Godfrey H. Hamilton, Secretary. West Riding Asylum, Wakefield.—Assistant Medical Officer. Salary, £150 per annum, with apartments, board, washing, and attendance. Applications to the Medical Director.

Berks County Asylum, Wallingford.—Second Assistant Medical Officer. Salary, £140 per annum, with board, furnished apartments, attendance, etc. Applications to the Medical Superintendent.

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The Hospital for Sick Children, Great Ormond Street, London,
W.C.—House Surgeon. Salary, six months £30, washing
allowance £2 10s., and board and residence in the Hospital.

Applications to the Secretary. (See advt.)

# Births.

Bunder.—On May 2nd, at "Endrick Bank," Honor Oak Park,
London, the wife of H. Marchant Bundey, M.B., C.M., of a
son. Australian papers please copy.
MICKLETMAIT.—On May 6th, at Hasilington, Crewe, the wife of
George W. Micklethwalt, M.D., of a daughter.

# Marriages.

BAKER—PARROTT.—On April 29th, at St. Mary's Hayes, F. C. J.
Baker, M.R.C.S., L.R.C.P., of North Molton, Devon, to Stella
Caroline, younger daughter of E. J. Parrott, M.R.C.S.,
L.R.C.P., of Hayes, Middlesex.
BOTS—WIX.—On May 8th, at St. Albans Abbey, Julius Claude,
second son of A. H. Boys, M.R.C.S., L.R.C.P., of St. Albans,
to Katharine Mary, youngest daughter of F. N. Wix, H.M.I.,
of St. Albans. of St. Albans.

# Peaths.

CHAFFERS.—On May 4th, at Abbotsrood, Grange-over-Sands, Edward Chaffers, F.R.C.S.Lond., J.P., aged 67.

Holdbrooke.—On May 6th, at Station Hospital, Poona, Cecil Holbrooke, Capt. R.A.M.C., youngest son of the Rev. F. G. Holbrooke, rector of Kimpton.

Hubson.—On May 8th, at Bank House, Bootle Station, Cumberland, Thomas Watson Hudson, M.R.C.S., aged 78.

Kynset.—On April 27th, at 12 Priory Grove, The Boltons, London.

Herbert Arthur Kynsey, M.R.C.S., L.R.C.P., D.P.H., only son of the late Sir William Raymond Kynsey, C.M.G., Kk., aged 41.

aged 41.

Martin.—On May 7th, at Westfield, Surbiton, Henry Arthur
Martin, M.D., late Army Medical Dept., in his 71st year.

RAMBAT.—On April 29th, at Cotswold Sanatorium, Herbert Murray
Ramssy, F.R.C.S., of 35a Hertford Street, London, aged 45.

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Supplied in two dilutions, respectively containing 10 and 20 millions of bacilli per c.c.

Mixed Vaccine for Acne, applicable where the staphylococcus and the acne bacillus are both present as pathogenetic agents, as in cases in which the lesions assume a sub-furuncular form.

Supplied in a dilution containing 500 millions of staphylococci and 20 millions of sene bacilli per c.c.

# GONOCOCCUS VACCINE.

Prepared from cultures of gonococcus. Applicable to the treatment of genecoccal urethritis and chronic gonococcal rheumatism.

Supplied in two dilutions, respectively containing 5 and 50 millions of gonococci per e.e.

## STREPTOCOCCUS VACCINE.

Prepared from cultures of streptococcus isolated from cases of erysipelas. Applicable to the treatment of streptococcal lymphangitis, erysipelas, and other strictly localised forms of streptococcus infection.

Supplied in two dilutions, respectively containing 5 and 20 millions of streptococci per c.c.

# **NEOFORMANS VACCINE.**

Prepared from cultures of micrococcus neoformans (Doyen), which is present in most, if not all, malignant tumours, and, though not to be regarded as the causal agent, is probably responsible for inflammatory changes and the pain associated therewith, as well as for much of the cachexia.

NEOFORMANS VACCINE is not suggested as a substitute for surgical procedures or as a remedial agent, but as an auxiliary in the treatment of cancer which is found to suppress local inflammation and apparently to diminish the cachexia.

Supplied in a concentration containing 30 millions of

# TUBERCLE VACCINE (Tuberculin-Bacillary Emulsion).

Applicable in particular to the treatment of chronic, strictly localised, and apprexic tubercular affections.

Supplied in two dilutions, respectively containing in each c.o. 1-2000 and 1-5000 milligramme of the comminuted tubercle culture.

The above-mentioned vaccines are supplied in hermetically-sealed glass bulbs containing rather more than 1 c.c., also in bottles of 25 c.c.

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Prepared from cultures of the typhoid bacillus. In two dilutions, containing, respectively, 1000 and 2000 millions of bacilli per c.c.
Supplied in sets containing one bulb of each dilution, providing complete treatment for one individual.

A pamphlet on "Vaccine Therapy" with general instructions for the use of these vaccines will be forwarded on request. Reference is also suggested to the articles published in *The Lancet* of Sept. 26, 1908, p. 925, and April 10, 1909, p. 1035.

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"A distinct advance on Easton's Syrup."



YNIN' AMARA is an analogue of Easton's Syrup, in which the sugar is replaced by an active Malt Extract. This affords a far better vehicle than syrup, as it is actively digestive and nutritious, and there is not the likelihood of the sugar crystallizing out, and carrying down in the crystal the alkaloid principle.

As a digestive tonic, the efore, 'BYNIN' AMARA is not only safer to take than Easton's Syrup, but is of greater value both in aiding and strengthening the powers of assimilation.

It has been found very effective in neuralgia and similar nerve troubles.

# COMPOSITION.

Quinine Phosphate					1½ grains.
Iron Phosphate					2 ,,
Nux Vomica Alkaloids	equal	to	Strychn	ine	16 ,,
'Bynin, Liquid Malt					1 ounce.

Dose for Adults-One dessert to one table-spoonful, suitably diluted.

A Sample Bottle will be sent free to Medical Men, on request.

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, MAY 19, 1909.

No. 20.

## Notes and COMMENTS.

More Dental

THE campaign against unqualified dental practitioners goes on, and success beyond anything previously Prosecutions. anticipated crowns the efforts of the prosecutors. Last week a Mr. E. L.

Robertson, of Brixton, was convicted and fined £10, and £2 2s. costs, by Mr. Hopkins, at Lambeth, for unlawfully taking and using an addition or description implying that he was registered, and that he was a person specially qualified to practise dentistry. The defendant pleaded guilty to the technical offence, though he contended that he had correctly stated his qualifications. On the same day, at the North London Police Court, Mr. Howard Bennett, of Hackney, was also summoned, he having been fined £10, and £3 3s. costs, for the same offence as recently as March last. Since that conviction, in order to regularise his position, he had put on his brass-plate the words, "not registered under the Act of 1878." The magistrate, however, held that the Act precluded the defendant from putting up any description implying that he was a dentist. He thought it permissible to put up a case of false teeth and the practitioner's name, but nothing else. Consequently he fined him £20, and £5 5s. costs. The day of the quack dentist seems drawing to a close, and, like the unqualified medical assistant, he will probably disappear from the scene.

WE do not remember the point Who pays having arisen in a court of law as the to whether the patient or the attend-Consultant? ing practitioner is responsible for the consultant's fee, but it was raised in the Romford County Court last week, and, unfortunately, not settled, owing to side issues. The parties to the action were Dr. W. Summerskill, as plaintiff, and Dr. Shepherd, as defendant, the former claiming for the return of certain articles and for board and lodging, the latter counter-claiming for professional fees for consultations. The judge decided against Dr. Shepherd on other grounds, so that the point, legally, remains in abeyance. It is deplorable enough that disputes of this kind should arise between medical men and be decided in public courts, and the fact that such differences may arise at any moment forms another of the strong arguments for joining one of the defence societies, as the councils of such bodies are always prepared to arbitrate, or to appoint an arbitrator, to decide matters in conflict between medical practitioners. Moreover, when such arbitration is offered by one party, and declined by the other, there can be little doubt as to which way the feeling of the profession would incline. The dignity of the profession demands that only in the last resort should fellow-practitioners fight each other in the law courts.

Divided

As to the point at issue, namely, responsibility for the consultant's Divided fee, we take it that no general rule Responsibilities. can be laid down. If the patient

or his friends wish to have the advice of a particular practitioner, and ask him directly to meet the usual attendant, there can be no doubt that they are liable. On the other hand, when the attendant asks for a consultation, and suggests a practitioner, and makes the arrangements himself, we gather that he thereby directly takes the responsibility himself, and he is therefore wise to see that the fee is forthcoming and paid over to the consultant before he leaves the patient's house. But between these two types of case there are many others, such as when the friends ask for consultation and leave arrangements to the attendant, or when the attendant requires a consultation, and leaves the friends to make an arrangement with a medical man of their choice, in which the responsibility is more evenly divided. Although a consultation is primarily undertaken for the benefit of the patient, it is also, in most cases, at any rate, a direct benefit to the attendant, both by relieving him of responsibility and strengthening his position, and it might be held in some cases that as he is a beneficiary he is concerned in the payment. But only in the most extreme cases can we imagine a consultant suing a brother practitioner for his fee.

A case of suicide which was remarkable in two ways
just been inquired into by
Dean Forest Coroner. In Euthanasia has the 10 Suicide. In the first place, the Coroner is himself a medical man, and the subject of the inquest was a patient of his own. Under such circumstances we cannot help feeling that, from the point of view of public policy, it would have been wiser had the inquest been held by his deputy. We hold that a coroner's duties are the functions, properly, of a medical man, and we should like to see all coroners trained medical men, but if cases like the present one arise they are sure to be quoted by those who consider the coroner's office is one for a lawyer. The other feature of this inquest was the coroner's evidence that the patient was suffering terrible agony from a malignant growth of the throat, and that he begged that something might be given "to send him out of the world quietly." In spite of reasoning and en-encouragement, the poor fellow said that no one could form any idea of his sufferings, but that he would try to endure them to the end. Subsequently he was found at the bottom of a well. Tragedies

so real and terrible as this one forcibly raise the question as to whether some official machinery should not be set up whereby sufferers from in-curable and intolerable diseases might be set free from their sufferings.

SEVERAL cases have occurred of late Medical in which medical men have unwit-Certificates for tingly granted to midwives certifi-Midwives. cates of good character, afterwards

shown to have been contrary to fact. There is, of course, no more absolute moral obligation in granting such a certificate than in giving the ordinary "character" to a domestic servant. In the case of midwives, however, the law has seen right to attach a greater degree of responsibility. In another column a brief report is given of a police court prosecution at Eccles, in which a midwife was accused of having gained admission to the midwives roll by a false and fraudulent certificate of good moral character, and a medical man for having granted the certificate. It was alleged that the midwife had more than a dozen convictions against her for drunk and disorderly conduct. The medical man was defended by the Medical Defence Union, and it was contended on his behalf that he had always found the female defendant capable for her business. The charge against the medical man was dismissed, but the midwife was committed for trial. The case shows that medical men should be extremely cautious in giving certificates of good character to midwives, as otherwise they may find themselves involved in extremely unpleasant consequences.

THE question of disputed responsibility bility for fees comes, sooner or later, within the average of the control of the contr for Fees.

cal practitioners. Some friend or relative engages the services of a medical man, but attempts to evade payment when that stage of the transaction is reached. The hands of the profession will be strengthened by a judgment given on May 3rd by Judge Bacon, in the Bloomsbury County Court. In the case concerned an action was brought by a medical man to recover fourteen guineas for certain professional services. Plaintiff stated he was consulted by defendant concerning the mental condition of a friend of hers, and he was given to understand she herself would be responsible for the fees. The reason for consulting him was that she wished the patient removed in order to prevent her marrying a gentleman she wished to marry herself. Apart from motives, however, we are glad to find that the judge took a clear and strong view of the legal position, namely, that plaintiff was entitled to his

within the experience of most medi-

" Preak "

plaintiff in her own interests.

WE have been accustomed to think that " freak " advertising had reached its highest point of development in Advertising. America, but last week we received a French circular which fairly out-

Herods anything we have ever met with before. No doubt our readers have received similar attentions from the firm in question, which, by the bye, is engaged in purveying a meat-juice. The circular bears on its outer cover a picture before which the indecent vulgarities of the more reptilian French comic papers might fairly blush. The scene depicted is that of an anatomist or surgeon dissecting a woman. One half of the latter figure is that of a naked courtesan smoking a cigarette, while the

fees, with costs. In this case the defendant was

not a relative of the patient, and admitted, under

cross-examination, that she had consulted the

other half shows her partially-dissected limbs. The mise-en-scène suggests rather the harlot's chamber than anything else, and the whole picture is repulsive in its suggestion of a connection between science and lust. What purpose the firm seek to subserve by such an atrocious outrage on good taste we fail to perceive, but it may perhaps be reassuring to them to learn that in this country any medical man who appeared to countenance such an advertisement would receive, deservedly, the reprobation of his fellows.

# LEADING ARTICLES.

GRINDERS' PHTHISIS AND DUST.

LAST week an important Home Office inquiry was opened at the Sheffield Town Hall concerning the disease alleged to be due to the unhealthy conditions under which the grinders of that city conduct their work. Despite the great advances that have been made since the old days of drygrinding, the mortality in certain "dusty" industries is still excessive. For instance, taking 100 as the death-rate from consumption amongst agriculturists, who are the healthiest class of the community, we find that there are several occupations in which the mortality is multiplied to the extent of three to four and a half times that ratio. The precise figures are: Potters, 453; cutlers, 407; file-makers, 373; glass-makers, 335; and coppermakers, 317. With regard to these figures, it may at once be unhesitatingly said that they represent an enormous and preventable waste of human life. It is peculiarly appropriate that the inquiry into this important matter should be raised in Sheffield, where, thanks to the labours of the late Mr. Simeon Snell and others the question of grinders' phthisis was long ago threshed out, and the modern crusade against industrial disease inaugurated. Much has been accomplished, but, with the above-quoted figues in view, it is equally evident that a vast deal remains to be accomplished. The ideal goal would be the reduction of serious respiratory diseases in the "dusty" trades to a level little above that of the agriculturist. Dust there must always be in connection with certain industries, but there are various ways in which the resulting risks may be materially diminished. The representative of the Cutlers' Company, Colonel Hughes, appears to have grasped the fundamental fact, that it is the quality of the dust which is the key to the position. Ordinary workshop dust may irritate the respiratory passages, but does not in itself produce phthisis, unless there be primary or secondary infection with the specific organism of tuberculosis. This proposition appears to be so self-evident and elementary that it is difficult to realise that in so important a trade centre as that of Sheffield it has not long ago been reduced to the working basis of a by-law. If, however, we turn to the history of sanitary progress generally, we find that it has in the main depended upon the tardy recognition by administrative bodies of more or less self-evident sanitary principles. At any rate, among the first facts elicited by the official inquiry is the crucial point that no steps are taken to exclude tuberculous grinders from the workshops, and that they are permitted to spit about the sheds without let or hindrance. Under such circumstances it appears to be somewhat of a farce

to take elaborate precautions to remove the mechanical dust which simply irritates the respiratory lungs, but to permit the constant contamination of the sheds by the sputum of tuberculous persons. Nay, more than that, it seems not improbable that by withdrawing the infected dust from the workshop the sanitary authorities may be distributing it broadcast and actively infective to the outside world. From a logical point of view, it is obviously necessary to get rid of the great predisposing factor in the spread of industrial phthisis, namely, dust. Then comes the problem of how to eliminate the specific germs of tuberculosis, which must reach the damaged lung by some route or other before the disease can be developed. One most elementary precaution is clearly to render the environment of the workshops as free from the tubercle bacillus in as thorough a manner as may be rendered possible by modern sanitary measures. This part of the problem, indeed, seems so self-apparent that we need not hesitate to anticipate the views of the Commissioner that in future regulations should be framed with a view of excluding tuberculous workpeople from the workshops, and of bringing under control the practice of spitting. These considerations suggest that there still remains much to be done in improving the environment of the factory and workshop. That something is radically wrong in the conditions of modern industrialism is shown by the testimony of Dr. Scurfield, the Medical Officer of Health for Sheffield, who has done excellent work in the past in the lessening of grinders' phthisis. He said the death-rate from that cause in his city was extraordinary, Birmingham being the only other town in England with anything like its record. The death-rate from phthisis among grinders was 15 per 1,000, as against 2.6 per 1,000 amongst all males over twenty years of age
—nearly six times as great. The death-rate was 5.6 per 1,000 from phthisis, as compared with 2.6 in the rest of the population, and from other respiratory diseases it was 7 per 1,000, compared with 2.1 per 1,000. Practically one-half of the grinders of Sheffield who had died during the past ten years had died of consumption. These facts point emphatically to the need of throwing fresh energy into the national fight against tuberculosis. It is only by the relentless extermination of all centres of infection that the battle will eventually be won. Meanwhile, the Sheffield Inquiry will have achieved much if it simply enforces the lesson that dust is a contributory, but not a prime, cause of industrial phthisis.

# CURRENT TOPICS.

The Future of Malaria Prevention.

One ever-present pitfall in administrative government lies in the determination of promotion. If by seniority alone, then it is tolerably certain that men will gradually rise to the most important posts, whether they have devoted themselves to the mastery of their professional work or otherwise. The square man in the round hole is an old-standing and familiar figure in official life. This risk has been lessened in some of the services by a preliminary weeding-out of unfit candidates by

competitive examinations. It seems probable that sooner or later the imposition of later examinations to test competency on promotion will become more or less the rule, more especially in those administrative branches that involve progressive technical knowledge. The general aspects of the problemwere vigorously dealt with in a direct fashion a short while since by Major Ronald Ross at the Royal Institution. He bewailed the failure of the hopes of the immediate success of the measures to combat malaria that were inaugurated ten years ago. "Malaria we know," he exclaimed, understand fully, we can beat down when we please. The battle which we are now fighting is against human stupidity." The gist of his criticism was that the sanitary administration of the West African Colonies had been wanting in leadership and organisation, and the campaign thwarted by administrative indifference and professional jealousy. He regretfully expressed his opinion that men, after receiving their medical qualifications, often went no further, read nothing, made no researches, and obtained the highest medical or sanitary appointments either by seniority or by the well-known acts of self-service and wire-pulling. This type of person was too common in all branches of British administration, and worse heads of departments could not be found. It is to be hoped that the Colonial Office will pay due heed to this crushing indictment, coming as it does from a man whose whole history forms a standing argument for the benefits that can be conferred upon communities by scientific and vigorous sanitary administration. In cur opinion the further statement by Major Ronald Ross that he has known young men in the Service who have been actually punished for acting as pioneers deserves authoritative investigation at the hands of His Majesty's Government.

# Objections to Post-mortem Examinations in Hospitals.

THE prejudice against interference with the human body after death is probably a natural one, and is, at any rate, one which must be reckoned with in our present civilisation. In the past it stood as an obstacle in the path of anatomical study, and at present in like manner it blocks the investigation of disease. No case of disease can be thoroughly studied without a complete examination of the body after death, and in private practice this is almost always impossible, and in hospital. work there are many difficulties in the way. In Ireland the feeling of the sanctity of the dead body is stronger than in England, and consequently it is even more difficult to co-ordinate the clinical facts with the anatomical conditions. The matter has long engaged the attention of those interested in the progress of medicine, but so far without much result. Lay committees are, as a rule, slow to adopt any stringent regulation on the subject, and consequently comparatively few bodies are available for pathological study. Much has yet to be done in the education of the public of all classes as to the reasons which require freedom of autopsy. Put in a nutshell, it is not, as is so often thought, mere curiosity which brings a physician to the postmortem room, but a desire that his next patient may have a better chance of life or of speedy

recovery. Early in the last century, in order to temove the prejudice against dissection, a number of enlightened and distinguished men made known their wish that their bodies should be dissected. It is possible that some similar pronouncement as regards post-mortem examination would do a little to dissipate public prejudices.

## Gratuitous Attendance in Street Cases.

THE more the medical profession does gratuitously for the good of the community, the greater the trespass made upon their good nature. The gratuitous attendance upon street accidents is a case in point. Such service is rendered, as a rule, by medical men without fee or reward, but there is no conceivable legal right on the part of anyone to demand gratuitous attendance of the kind. We are glad to see that the point has been vigorously taken up by the Hartlepool division of the British Medical Association. The immediate cause was a newspaper attack upon a local medical man who had been called to a street case, but was not informed of its serious nature, neither was he given an opportunity of attending the subsequent inquest. The Society also emphatically claim that it is no part of the duty of a district medical officer to attend street cases. They further submit that, as it is the duty of the police to look after injured persons, they should also call in and pay for medical attendance. The Hartlepool division certainly deserve the wholehearted support of their brethren in the attempt to induce the proper public authorities to act "with a view to the medical treatment of street accidents and emergencies being placed on a proper businesslike footing."

## How to Fight Urban Tuberculosis.

THE attempt to fight tuberculosis in the United Kingdom by the aid of huge and costly sanatoria has not proved an overwhelming success, to put the matter mildly. As a means of coping with the disease amongst the poor and the less wealthy middle classes the plan is practically useless. The idea of erecting great blocks of model tenements for the tuberculous poor of cities does not appear to have occurred to any of our leading sanitarians as a feasible and desirable scheme. It has remained for America to bring forward the proposal, and for an American millionaire, in the person of Mrs. Vanderbilt, to furnish the large sum of money required to reduce the scheme to a working basis. That kind-hearted lady has undertaken to build large blocks of tenements so constructed with gardens and balconies that it will be possible to carry out the open-air treatment. It is interesting to learn that this practical philanthropist has not only given a million dollars for the cause, but has actually visited the consumptives and studied their wants in their own homes. There is a good deal worth careful consideration in this new departure. The experiences of Mount Vernon Hospital show that tuberculous patients can sleep outside at all times of the year, even in the midst of a dense London fog. It would be a comparatively easy matter to fit up some small sanatoria experimentally on the lines adopted by Mrs. Vanderbilt, and it is to be hoped that British philanthropy would speedily rise to the occasion were it shown that the open-air tenement block is a suitable kind of building for the treatment of tuberculosis in our great centres of population.

# Operations v. Military Law.

THE value of the army as a military machine depends primarily and essentially on discipline, and the sacrifices that are necessary to that end are frequently great. A soldier who swears to obey his officers does so blindly, and, theoretically, if he is told to charge singly against a squadron of cavalry or a battery of artillery he has no option but to obey. Does his duty entail submission to the advice of his medical officer to undergo an operation? In the British Army we believe it does, though we have never heard of a case in which it was necessary to turn the advice into an order. The question has lately arisen in Germany, where a private refused to undergo an operation, and, with Teutonic thoroughness, he was promptly courtmartialled and sentenced for disobedience. His case, however, has excited much interest among jurists, and several eminent lawyers have come forward on his behalf to argue that surgical operations are outside the category of military duties, and therefore he has a right to refuse. If the refusal was unreasonable, and the disease interfered with military duties, we take it that this argument would not hold water, but in any case it is most undesirable that such stern steps should be taken, except in case of extreme necessity. In this country, at any rate, we hope that no similar case will arise. It can add nothing to the respect in which the profession is held, and might do a great deal to damage it.

# A New Method of Watching Operations.

THE difficulty of arranging matters so that students shall be enabled to watch surgical operations has greatly increased under modern methods. It is now necessary to restrict the number of those present to a minimum, as the risk of sepsis is increased by every additional person present. The cinematograph gets over the difficulty only to a limited extent, besides which it is costly and cumbrous. An American-Dr. Charles H. Duncanhas introduced a most ingenious plan whereby the students may sit in an adjoining room and watch every step of an operation at their leisure. Above the operators is a large disc, fitted at its periphery with a number of electric lights. By a series of lenses and mirrors a view of the area beneath the disc is projected on a screen in the students' room. As the picture is taken from above, every movement of the surgeons and every detail of the operation around is visible, and the inconvenience of the interposed bodies of surgeons and assistants, whereby the ordinary view of an operation is often completely spoiled is avoided. The educational value to students of witnessing actual operative procedure is so great that any method which renders that privilege more generally available will be hailed as a boon in the medical schools. The instrument is named a "projector."

# PERSONAL.

MISS FLORENCE NIGHTINGALE, O.M., entered her ninetieth year on May 12th last. We cordially offer her our congratulations.

THE authorities of the University of Toronto express great pleasure at the acceptance by Dr. Leathes, of London, of the Chair of Clinical Pathology at the University.

Dr. David N. Knox has been elected representative on the General Medical Council of the Glasgow Faculty of Physicians and Surgeons in succession to the late Dr. Lindsay Steven.

SIR SHIRLEY F. MURPHY was the recipient, on Thursday last, of the Honorary Fellowship of the Royal College of Surgeons of England. His membership dates from 1870.

MR. ERNEST MALLAM, D.M., Magdalen College, has been appointed Litchfield Clinical Lecturer in Medicine in the University of Oxford for a term of two years from October, 1909.

DR. STUART M'DONALD, M.D., F.R.C.P.Edin., of the University of Edinburgh, has received the important appointment as Professor of Pathology in the College of Medicine, Newcastle-on-Tyne.

Dr. James Hurd Keeling, M.D., of Sheffield, whose death was reported in these columns a few weeks since, has left £250 each to the Jessop Hospital for Women, Sheffield, and the Sheffield University.

DR. JOHN KEAY, Medical Superintendent of the Bangour Village Asylum, has been appointed, jointly with Sir J. Batty Tuke, Lecturer on Mental Diseases in the Extra-Mural School of Medicine, Edinburgh.

The honorary degree of LL.D. of the University of Liverpool was conferred on Sir Donald MacAlister, K.C.B., on May 8th. At the same congregation Dr. J. T. Todd was presented with the honorary degree of D.Sc.

PROFESSOR G. SIMS WOODHEAD, M.D., has been re-appointed by the Council of the Senate of the University of Cambridge as representative of the University of Cambridge on the Council of the Lister Institute of Preventive Medicine.

THE Poor-law Medical Officers' Association of England and Wales will hold its annual meeting this year on July 6th at the Guildhall, London, at which a conference will be opened on the report of the Royal Commission on Poor-law Medical Relief.

MR. CHARLES A. BALLANCE, M.V.O., F.R.C.S., Surgeon to St. Thomas's Hospital, was elected last week a member of the Court of Examiners, Royal College of Surgeons of England, in the vacancy occasioned by the retirement of Mr. A. Pearce Gould.

Dr. MAJOR GREENWOOD, jun., will give a course of four lectures on "Satistical Methods in Physiology and Medicine" at the London Hospital Medical College on May 21st, June 4th, 11th, and 18th. The lectures are at 4.30 p.m., and are free to all students of the London University.

SIR WILLIAM S. CHURCH, BART., K.C.B., M.D., will preside at the fourth annual meeting of the Convalescent Homes Association to-morrow, Thursday, May

20th, at 4.30 p.m. The report for the year 1908 will be submitted, and the object and work of the Association will be explained.

PROFESSOR PFEIFFER, Director of the Hygienic Institute, Breslau, will deliver the Harben Lectures of the Royal Institute of Public Health this year. The lectures will be given on June 21st, 23rd, and 25th, at 6 p.m., and will deal with subjects connected with immunisation and virulence.

M. PAUL CAMBON, the French Ambassador,, presided over the 41st Annual Dinner of the French Hospital, held on Saturday evening, at the Hotel Cecil, London. It was attended by the Spanish Ambassador, M. de Villa Urrutia, the Lord Mayor, Sir George Wyatt Truscott, and the Sheriffs.

THE Jacksonian Prize of the Royal College of Surgeons of England has been awarded to Mr. J. P. Lockhart Mummery, author of that very popular handbook, "The After-Treatment of Operations." The John Tomes Prize in Dental Surgery has been awarded to Mr. Arthur Swayne Underwood.

Dr. George H. Gibson will give the Opening Address at the Medical Faculty of the McGill University, Montreal, on September 22nd. His subject will be "The Limits of Knowledge." On June 9th Dr. Gibson is to have the honorary degree of LL.D. conferred upon him by the University.

AMONG the witnesses who appeared before the Departmental Committee to consider the working of the Midwives' Act, at their last meeting, were Mr. Sydney Stephenson. Dr. Sidney Barwise (Medical Officer of Health for Derbyshire), and Mr. Walter Schröder (Deputy-Coroner for the Central District of London).

MRS. MACLOGHLIN, late of Southport, has offered to the Royal College of Surgeons, London, a work in bronze and marble by Mr. Alfred Gilbert, M.V.O., The gift has been accepted with the best thanks of the council. The work, which is life-size, and portrays Mrs. Macloghlin and her late husband, Mr. E. Plantagenet Macloghlin, M.R.C.S., is to be placed in the entrance hall of the college.

WE regret to hear that Dr. Bucknall, when motoring from Hastings to Maidstone last week, met with a serious accident, when, on turning a very sharp corner just outside the former town, the car swerved on to a bank and overturned. Dr. Bucknall and his companion were thrown clear of the vehicle, and sustained serious injury, while the chauffeur, who was hurled over the edge, was picked up in an unconscious condition.

ROYAL ARMY MEDICAL CORPS.—Colonel H. J. R. Moberly, Maymyo, has been appointed officiating P.M.O., Presidency and Assam Brigades. Lieut.—Colonel F. P. Nichols has been appointed to the command of the station hospital, Jullundur. Major M. P. Corkery, Jhansi, has been appointed a specialist in the prevention of disease, and Captain H. M. Nicholls, 6th (Poona) Division, a specialist in ophthalmology. Major C. C. Fleming, D.S.O., is to take up the appointment of instructor at the Royal Army Medical Corps School, Aldershot, on June 13th, in succession to Major J. D. Ferguson, D.S.O.

# A CLINICAL LECTURE

**ON** 

# THE FEEBLE-MINDED AND THEIR CARE. (a)

By GEORGE H. SAVAGE, M.D., F.R.C.P.Lond.,

Consulting Physician and Lecturer on Mental Diseases, Guy's Hospital; Consulting Physician to Earlswood Asylum, &c.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

PART I.

GENTLEMEN,-I feel that to-day's subject is both medical and social, and it is of the very gravest importance. No doubt many—and probably all—of you have seen the very voluminous Report of the Com-mission on the Feeble-minded which was sitting for mission on the Feeble-minded which was sitting for some years, the report consisting of eight volumes, the eighth volume, containing the summary, being the most important. I have felt especial interest in this, for I was requested to contribute an analysis of this report for the *Quarterly Review*. The term "feeble-minded" has to be looked at from two or three very distinct points of view. The Commissioners first accepted the definition of the College of Physicians, which is this: "A feeble-minded person is one who is which is this: "A feeble-minded person is one who is capable of earning a living under favourable circumstances, but is incapable, from mental defect existing from birth or from early age, of competing on equal terms with his normal fellows, of managing himself or his affairs with ordinary prudence." The introduction shows that, first, all persons who, whatever the form or degree of their mental disorder, are unfitted to take part in the struggle of civilised life, are to be considered as feeble-minded. The second principle is that persons suffering from disease should be looked upon rather from the standpoint of disease than the social That, of course, implies a good deal. Some people have said that to have a drunken relation is bad enough, but to have to sympathise with him is still worse. But we have to accept the fact that there are certain feeble-minded people who do not fall into social step, who are unable, unaided, to earn a normal living under normal conditions; therefore, many of them must be treated as sufferers rather than sinners. The third principle is, that if the mentally weak are to be properly recognised and treated, their condition must be reported early. In referring to this subject I have had to point cut the all-importance of early recogmition of the disorder. If any good is to be done you must catch your youths very early. The fourth principle is that the control or treatment must be continued as long as needed. One of the great difficulties we all have who have to deal with the weak-minded or the insane is, that as soon as they have reached a certain standard they are discharged recovered. course, there are many people who have reached the level of reason without being sound. I have said over and over again that because they are perfectly reasonable they are not necessarily perfectly sane, or that they are perfectly fit to return to their old occupations. You might just as well say of a person who has had typhoid fever or some other febrile illness, directly the temperature registers 981° he is fit for anything and everything. In the same way there are many people who are feeble-minded, and yet, up to a certain point, are reasonable. But if in future the suggestions are carried out, people, when they have been recognised as permanently feeble-minded, are not to be returned to society—they are not to be returned, at all events, until it is quite assured that they are trustworthy. That is a very important principle in the consideration of the feeble-minded. The fifth principle is that it is essential that the whole of the insane and weak-minded should be under one definite line of control. At present some weak-minded people come under the Educa-tion Board, certain others fall to the prisons, many others come under the infirmaries. It is suggested

(a) A Lecture delivered at the Polyclinic, London, on Thursday, May 6th, 1909.

that in the future, when it has been clearly defined who the feeble-minded are, they should all be under one definite head. This, perhaps, is a counsel of perfection. We are hardly advanced socialistically enough—or autocratically enough, you might say—to be able to put on one side all those whom we consider not to be strong-minded. There is such a thing as the tyranny of the majority as well as the tyranny of the individual, and at present, desirable as it may be that a large number of these feeble-minded should be put on one side, it is certain that at present we cannot do it, because, according to these principles and according to the definitions, we shall have to include too many as feeble-minded. The Commission definitely point out that every person who is deficient intellectually, but above the grade of idiot and imbecile, but who cannot earn an independent livelihood unaided or uncontrolled, has to be regarded as weak-minded. Such are, of course, intellectually weak-minded. They would also consider, as I shall show presently, that the morally defective—those who tend to dishonesty and vagabondage and to immorality—should be controlled. And that those who are inebriates should certainly be isolated. And, as I shall consider presently, it is not putting on one side temporarily, but, as I read to you just now, the control and treatment must be continued as long as it is needed. And I am afraid the experience of a large number of people is that the control required is life-long. And then, again, epileptics have to be considered; not all epileptics. But the epileptic as a class has to be looked upon as feeble-minded, and it is felt that they certainly should be segregated. The whole principle, then, of social treatment of these weak-minded people is that they should be prevented from propagating. That, of course, is a very wide and large subject, and I suppose it is a subject which some of you would say becomes more social than medical.

medical.

I have pointed out, then, the principles on which the Commission, in investigating these cases, acted; and I have pointed out the nature of the Report, which was carried out in the most thorough way. And yesterday, when I was putting some of these notes down, I could not help noticing in front of me an advertisement—I think from the Cambridge Press—of the "Evolution of the Vertebrates." Naturally, I could not help thinking of the Evolution of the Invertebrates, these backboneless people who are constantly in evidence nowadays. There is no doubt it is of the utmost importance that they should be separated, and that they should be trained.

The first point for our medico-legal consideration is that these are people who are not certifiably insane. Facts observed by yourselves indicating insanity have to be put on your medical certificate. In the majority of these cases there is nothing you can put down as observed by yourself. I believe the time will come when certificates will be modified. Already the certificate required for the detention of an idiot or imbecile differs from that for the ordinary acute lunatic; and there is no doubt that when the feeble-minded are properly cared for, some special form of certificate will be obtained. But the people we are considering are those who are not certifiable. They may be sent to the infirmaries, or they may be sent to the workhouses, but they are not certifiable lunatics. There are the intellectually weak, who are weak all round. There are a large number who were so-called backward as children; and one of the most

serious points is that a very large proportion of distinctly backward children are never anything else. When the question of the education of the feeble-minded was first brought before society, a Duchess of distinction took a deep interest in the matter, and came to the conclusion that the feeble-minded were like many feeble people, that they had only to be trained, and then they would be as good as anybody else. But she soon found that the backward child who was organically backward was deficient, and that you could never make up that deficiency. And it is on that principle that a great deal of this legislation is founded: that the majority of them are permanently weak. They begin with a bad start in life, and are intellectually defective. Already a large provision is being made for those who are physical cripples, but mental cripples need homes, and the help, too, of Lord Mayors.

There are also those who are defective in their senses: blind, deaf, and dumb. But when we come to the next class, the morally defective, we find that very little provision is made, beyond prisons and reformatories. A very large group of so-called wasters are allowed to run amok. It is a common experience of mine to be consulted about a waster with such a history as this:—His grandfather made a huge fortune in some speculation or invention. The next generation went on "guarding the heap." Then comes the next generation, with a reserve of energy which has got no objective, and they go to the bad, in one way or another. And some would say, "A good thing, too; the heap has been raised, and now it has been scattered again." If it were a mere scattering, I would say, "By all means." But the scattering not only damages the waster, but is also injurious to other people, and it is the other people who suffer, much more than does the waster. In setting fire to a building what we have to consider is the other damage which may be done. Just as one saw recently: a small boy amused himself by setting fire to a small piece of furze, and the result is it burns commons for miles. How shall we secure the waster legally? I hardly know, for many of those individuals are intellectual enough, but they may be wanting in what we call the moral sense. The same with inebriates. It is perfectly certain that some inebriates will never be cured, do what you will for and with them. It would be a good thing if they could be put on one side; but I am afraid that at present we cannot do it. I am speaking to those who will each have some influence in regard to legislation in the future, and the question is, What will have to be done with regard to these?

As to epileptics, there are epileptics and epileptics. It has been said that genius, as in Napoleon and Mahomet, may be associated with epilepsy. But it is certain that there are some who might be termed casual epileptics and who are brilliant men, and it would be a sin to look upon them as anything else. The great point is to prevent those epileptics who are constantly epileptic from having offspring. There are those who begin with epileptic fits in early years and should be educated apart. There is a large group who come into the world weak and handicapped from birth, and such never get strong. They are backward, delicate children, and are always subject to rages or fits; they do not develop normally. There are others who, perhaps, reach adolescence or maturity and seem to be like eight-day clocks. They are wound to go eight days, and then they stop. There are certain individuals who seem to be wound up to reach adolescence, and then they break down and become permanently weak-minded. So there are, first, congenitally weak-minded; and, secondly, there are those who are consecutively weak-minded. Some time ago, at Treloar's Cripples' Home, I gave a talk on Mental Cripples, those who were permanently feeble in mind, the mental weakness resulting from some physical disease. A man may be crippled morally after an attack of insanity; he may be crippled morally after an attack of insanity; he may be crippled morally after an attack of insanity; he may be crippled morally after an attack of insanity; or he may be crippled physically after such an attack. Another point, which I think the Commission hardly grasped, is, that if you are to seclude those who are likely to add to the insane population if they marry, there are a large number of people who are regularly insane, just as the epileptic may

have regular fits, so there is a large group of patients who have recurring insanity; they have a cycle; they are depressed, they become wildly excited, then become dull, apathetic, almost weak-minded for a time. They are fairly reasonable, or quite reasonable for a time; then there comes another attack, and another. Are we to consider them as permanently weak-minded people? At present, not.

What is the cause, generally, of this type of mental

What is the cause, generally, of this type of mental weakness? Undoubtedly heredity is the strongest and most dangerous thing. Not only direct inheritance from acute insanity: that is not so severe. I have sometimes said that the danger of an acutely insane parent having an insane child is comparatively little, compared with the certainty of a weak-minded epileptic or physically degenerate having a feeble-minded child. I was obliged to make use of a fairly forced simile. Geniuses, as a rule, do not have geniuses as sons; lunatics frequently do not have lunatics as sons, but weak-minded people do. There is a much graver danger of the transmission of what might be called slight deviations from the normal. It is in accordance with everything which Darwin taught, that it is the slight modifications which are transmitted. Just as genius is an occasional thing, so, fortunately, often insanity is; a genius in a father often does not mean a child genius. But a weak-minded father and a weak-minded mother beget offspring who are easily misled. I see a number of children who are the products of senility: children begotten of very aged fathers, and sometimes of mothers who are near the climacteric. Of course, a healthy old man may have a healthy child. But the lust which is often associated with lack of higher control often has a sequel weak-minded children. A child begotten of a father who has general paralysis of the insane stands a good chance of being imbecile or permanently weak-minded.

Parental vice, such as drink, is a very serious question. Then there is the effect of tuberculous parentage. It is pretty certain that a parent who is physically weak from tuberculous disease may tend to have feeble offspring, and those feeble offspring may be feeble in mind as well as feeble in body.

Another important question which will often be brought before you is that of consanguinity. You will be asked, Is simple consanguinity likely to cause feeble-mindedness? It is a common idea that cousins should never marry. So often am I consulted on this question that I sometimes say I must have one of my rooms labelled "Marriage Bureau." Parents, as a rule, are dead against the marriage of cousins. When you come to review a large number of cases you find the truth is that if there are neuroses in either branch of the families it is a very dangerous thing. If there are neuroses in either family, I should say avoid an important point.

To conclude, then, some neuroses are much To conclude, then, some neuroses are much more readily transmitted than are others. There is a simple all-round feebleness. Such are said to be easily led, to be wanting in will, wanting in adaptability. All these simple things are readily transmitted. Anything allied to epilepsy seems also to be likely to be represented in the next generation by feeble-middeness. One has also to represent the child mindedness. One has also to remember the child who might otherwise have developed all right, but who is affected with some acute disorder in early life, especially if that disorder be a nervous one. care, such may be reared and trained to become useful members of society. One child having convulsions at two years of age, has never been the same child since Many children been the same child since. Many children become weak-minded as a result of some febrile attack children I saw a child the other day who was said to have had I suppose meningitis is sometimes remeningitis. covered from, but many children who have febrile attacks have not meningitis; but they may be left permanently weak-minded. A point which interests me very much is the frequency with which feeble-minded children are found to have had, early in life, some interference with respiration. You get a history that the child was all right until it had measles, followed by bronchitis. A still more common occurrence is to find permanent mental enfeeblement follow whooping-cough. That in itself is a nervous disorder,

and it is a very common thing for me to find, in the history of these weak-minded people, that there has been whooping-cough.

NOTE.—A Chinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by George H. Savage, M.D., F.R.C.P. Lond., Consulting Physician and Lecturer on Mental Diseases, Guy's Hospital; Consulting Physician to Earlswood Asylum, &c. Subject: "The Feeble-Minded and their Care."—PART II.

# ORIGINAL PAPERS.

# BLACK WATER FEVER AND THE INTIMATE PATHOLOGY OF MALARIA. (a)

By Dr. C. A. BENTLEY AND

CAPTAIN S. R. CHRISTOPHERS, Indian Medical Service.

THE malarial origin of Black-water Fever is generally admitted; but there is still a considerable amount of misconception regarding the relationship between malaria and this disease. In the first place it is necessary, of course, to disabuse minds entirely of the idea that in an attack of Black-water Fever we see anything of the nature of a malarial paroxysm; Koch once and for all disposed of such a view.

So in regard to Black-water Fever we can say that

it is never so far as we know a result of one or two attacks of malaria, however severe they may be. It is a new condition, the outcome of malaria under certain circumstances. In the limits of our present paper we cannot do justice to a description of the very definite circumstances in regard to malaria which bring about this condition. We may note only that we require :

(a) A person highly susceptible to malaria, whether this show itself as "fever," or as long-continued infection, with perhaps only vague and uncer-tain symptoms, unrecognised, but none the less dangerous.

(b) Conditions as regards malaria which lead to the certainty of almost daily inoculation with sporozoa. Such conditions are of widespread occurrence on the malarious coast of Africa, but, as

all will probably acknowledge, do not occur in ordinary life in the plains of India.

(c) These conditions must act continuously for a certain time—if exceedingly intense, or in the case of a very susceptible person during six case of a very susceptible person during six months, or in very rare instances three months, but usually for a period of about eighteen months or two years.

DIFFERENT SPECIES OF PARASITE.

Let us consider for a moment some of the special features of the different species of the malaria para-

we are concerned with three species:—The Quartan, the Simple or Benign Tertian, the Malignant Tertian.

Everyone is familiar with the differences between these three types and the broader characteristics of the respective infections produced by them. But there are certain points which appear to have a special importance in connection with the matter under discussion, and it is necessary to refer to them, particularly as the study of malaria is not often approached from

the point of view we are indicating.

In malignant tertian infections some of the most noticeable features of the condition are:

- The absence from the peripheral blood of sporulating bodies, and the disappearance of parasites from this situation once they have reached a certain stage of their existence.
- The tendency for the accumulation of the infected corpuscles in the visceral capillaries.
- (a) Paper read before the Indian Medical Congress at Bombay,  $F_{\rm cbruary, 1909}$ .

- (c) The frequently recorded marked alteration of the infected red cells-(globuli rossi change)
- Specially active phagocytosis of infected cells.
- The great tendency for infections by this species of parasite to produce pernicious symptoms, often simulating definite organic disease as of the brain (comatose and delirious forms), the intestinal system (algid, choleraic and dysenteric forms), the lungs (pneumonic form), and, according to some observers, other manifestations such as a form of pleurisy, etc.

  In infections by the quartan and simple tertian parasites, on the other hand, we find:—

  (a) Sporulating bodies appear very frequently in the peripheral circulation

peripheral circulation.

(b) There is not the same tendency for infected red corpuscles to be held up in the visceral capil-

(c) Phagocytosis of infected red cells is exceedingly rare, Thayer stating that he has never observed

(d) Pernicious attacks are rarely if ever encountered in the course of infection by either of these two species of parasite.

Are the different phenomena observable in the case of infections by the malignant tertian parasite, for example, inter-related? And, again, are the different effects produced by each species of parasite due merely to the characteristic behaviour of these parasites, or is there some fundamental pathological principle underlying them all?

BLOOD DESTRUCTION.

Let us before answering these questions turn to the consideration of certain data connected with blood destruction in the body. If we add some hæmolytic uestruction in the pody. It we add some hæmolytic agent to a suspension of red blood corpuscles in vitro, we shall under suitable conditions produce a solution of the cells. This being so one is tempted to think that the profound destruction that may follow the injection of the conditions of the condition of th the injection of a hæmolytic agent into the body, may be due to a simple solution of the red cells, resulting from the direct action of this hæmolytic body, such as occurs in the test-tube. But this conception does not accord with the facts.

By injecting a goat with dog's blood we prepared in the ordinary manner a hæmolytic serum which, under suitable conditions, showed a strong solvent action for dog's corpuscles. The injection of a large dose of this serum into dogs was followed by a rapid, uose or mis serum into dogs was followed by a rapid, profound and progressive anæmia, resulting in death. Here, then, we might be tempted to suppose that there had been a solution of the dog's red cells. In the case of many animals, however, in spite of extraordinary anæmia brought about within a few hours by the toric serum, there was no evidence of red cell solutions. ordinary anamia prought about within a few hours yethe toxic serum, there was no evidence of red cell solution. Hæmoglobinuria did not occur, nor did a careful examination of the blood show the presence of hæmoglobinæmia or shadow corpuscles. Moreover, though the tissues on post-mortem examination show great pallor, there was none of the yellow staining characteristic of the condition mentioned later, in which solution of the red cells had actually occurred. Further examination of the organs showed that the rapid and enormous blood destruction was not of the nature of solution at all, but was due to an extraordinary phagocytosis of red corpuscles and the holding up of these blood elements in the capillaries, notably those of the spleen and liver. The condition of affairs in the different experiments could be seen to vary from some congestion of an organ associated with red-cell phagocytosis to the most extraordinary Moreover, hæmoglobinæmia or shadow corpuscles. with red-cell phagocytosis to the most extraordinary condition where the whole spleen was converted into

a mass resembling a thrombus.

But by a regulation of the dose of the serum we found that another result could be obtained. A lesser dose produced, as before, severe and rapidly progressive anæmia with a similar holding-up and phagocy-but and the visceral capillaries. But very tosis of red cells in the visceral capillaries. But very often when the anæmia had progressed for twentyfour hours or more there supervened a new phase; for the first time the plasma now showed free hæmoglobin. the urine became hæmoglobinous, and the tissues after death showed the characteristic yellow staining so well seen in Black-water Fever. In this phase, too, in blood from the hepatic and renal vessels we found shoals of stromata and decolorised red cells.

Two Distinct Processes.

Two distinct processes may result, therefore, from the action of a hæmolytic serum in vivo:—

the action of a hæmolytic serum in vivo:—

(a) An easily produced and constant effect due to the holding-up in the organs and ultimate phagocytosis of red cells;

(b) And a condition which may or may not supervene, characterised by actual solution of the cells within the blood stream, the accompanying hæmoglobinæmia being followed by the occur-

rence of hæmoglobinuria.

For convenience of description and because at the time no suitable names existed for these two newly-recognised processes, we termed them, respectively, "Erythro-katalysis" and "Lysæmia." These terms, although not perfect, appear to answer their purpose

for the present.

Why then, we may now ask, do we not get hæmoglobinuria in the course of an ordinary attack of malaria, however severe? Because we can say, it must be that the destruction of red cells in malignant tertian malaria is not due to "lysæmia," a condition which would produce Black-water Fever, but to "erythro-katalysis." How far erythro-katalysis is concerned in blood destruction by simple tertian and quartan malaria we do not know, but here we seem to have another factor, for in these infections disruption of the red cell occurs only when it no longer contains an appreciable amount of hæmoglobin. There appears, therefore, to be little doubt that the action exerted by the malignant tertian parasite upon the red cells differs in a marked degree from that exhibited by the parasites of the other two species. And this peculiar action is chiefly demonstrated by the induction of a condition which renders the corpuscles especially susceptible to destruction by erythro-katalysis, so leading more than in the other infections to a holding-up of infected cells in the visceral capillaries.

The tendency towards an extensive phagocytosis of damaged cells is also in accordance with the general pathological principle. The absence of sporulating bodies is also obviously due to the same; and we could, if time were not pressing, show that the change in globuline rossi corpuscles, a change which we have noted and which is well known to be very common in malignant tertian malaria, is a condition exactly resembling that brought about by erythro-katalytic terrian such as well as the contraction of the same of the same; and we have the same of the same; and we have the same of the same; and we have the same of the same; and we have the same of the same of the same; and we have the same of the same; and we have the same of t

toxins, such as we have used experimentally.

And similarly herein appears to lie the possible explanation of the association of the pernicious attacks with the malignant tertian infections. Perniciousness being the result of the stasis produced and the subsequent clogging and infraction of the capillaries. The generally severer and more lasting effects of malignant tertian infection, their more insidious course, the frequently anomalous symptoms, the continuance of fever for days in spite of specific treatment and when parasites cannot be found, should make us give due consideration to the fact that in this disease we may have a condition of erythro-katalysis produced, similar to that which studied experimentally can be seen to lead to quite marked organic disease. (We may remark here, in parenthesis, that experiments on dogs have suggested to us the possibility of erythro-katalysis in a marked degree being concerned in the causation of post-hæmoglobinuric and certain other anomalous fevers, such as the "symptomatic fever" of Kelsch and Keiner, in which a febrile condition exists uninfluenced by quinine and apparently unrelated to any specific cause, but associated almost invariably with evidence of continued blood destruction.)

CAUSATION OF BLACK-WATER FEVER.
What relation do these observations bear to the

causation of Black-water Fever?

We have previously referred to the fact that by immunising an animal of species A against injections of the red corpuscles of species B, we produced in A a serum capable of dissolving the blood cells of B in vitro, and when injected in vivo of producing symptoms under certain conditions closely resembling those of Black-water Fever. It may be asked whether it is possible to produce a similar effect by injecting an

animal with blood from another individual of the same species. This is possible, for Ehrlich and others have produced in this way a number of different iso-lysins. Still further pushing the question we may ask if it is not possible to immunise an animal against its own blood cells? This has been attempted, but it is not easy, apparently because of certain regulating powers possessed by the organism, which largely serve to protect it from such a condition. Nevertheless, Ehrlich records that he did once produce an autolysin in this way. Under pathological conditions, however, we often meet with effects that we cannot produce experimentally, and the occurrence of autolysins as a result of disease is very probable.

of disease is very probable.

What actually happens during the process of immunising an animal of species A to the red cells of an animal of another species B? Metchnikoff has investigated this question and states as the result of numerous experiments that whenever foreign blood cells are injected into an animal, the primary phenomenon to be observed is an extensive phagocytosis or resorption of the foreign blood elements. In attempting, therefore, to produce an autolysin experimentally we endeavour by some means to force an organism to deal repeatedly with its own red cells in the same manner that it would act towards foreign blood corpuscles; in other words, we attempt to stimulate the resorption of a large number of an animal's own blood

cells.

In Black-water Fever, as we have already indicated, we have reason to believe that we are not dealing with the effects of a toxin elaborated by the malarial parasite, but with the action of substances produced by the human organism itself; in other words, with the effects of an autolysin. And if human autolysin is to occur, can we think of any diseased condition more likely to produce it than malaria? Malaria actually gives rise within man's body to the very condition we try to bring about in the attempt to produce an autolysin experimentally. Under the circumstances which appear necessary for the occurrence of Black-water Fever, the peculiar character of which we have briefly indicated, it is obvious that repeated and persistent blood destruction and resorption must result, and we see again that if our hypothesis, which is only hypothesis, be the true one, why the malignant tertian parasite, its special action upon the red cells and consequent stimulation to their phagocytosis, should above all be the one concerned in the causation of Black-water Fever

All this is, of course, hypothesis, but it may serve its purpose of indicating in a very broad and general way how Black-water may be malarial in origin and yet not be malaria.

# ACUTE MULTIPLE SCLEROSIS.

By Professor HERBERT KOCH, M.D.,

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

of a disease often difficult to diagnose and more unsatisfactory to treat. It is eminently a chronic disease, but cases are on record where an acute form has attended a group of these multiple centres. Marburg seems to have been the first to recognise this fact of rapid inflammatory centres in his disquisition on the so-called "Multiple Sclerosis." In this exposition of the subject he includes a series of acute cases culled from literature of its history. Bischofskys, Schobs and Volsch have also given examples in multiple sclerosis of an acute character, while others have included myelitis in their clinical history. From the proximity of the morbid changes it is easy to understand how multiple sclerosis and myelitis can be represented in the same clinical group. The follow-

ing minute and detailed history may serve as a classical example of the clinical history and

pathological anatomy of the disease: -Alois, æt. 30, fireman, had always been well from childhood, even without history of any of the children's diseases. Had a good family history, and no trace of any nerve disease to be discovered. Last year he was attacked with erysipelas in the face, from which he soon recovered. Three weeks ago, after a heavy day's work, he felt tired and exhausted, particularly in the left leg, which was numb and void of feeling, this extending from the hip to the toes. This paræsthesia extended to the left side of the penis, but the right remained perfectly normal, stopping exactly at the middle Next day as patient endeavoured to go to work he found that both legs were feeble and locomotion difficult. Eight days later patient was unable to move, the feet being quite helpless. From this time difficulty in urinating commenced, as well as in defæcation, the patient not knowing either were performed, except by ocular demon-The paræsthesia steadily increased when looking at a book or newspaper. Observed that the grasp of both hands was weak, that the thumb and index finger of the right hand were paræsthetic, but the paræsthesia of foot almost gone, while the right leg had become powerless. 28th.—Paræsthesia in the middle finger of the right hand appeared for the first time; 30th.-Paræsthesia invaded the whole of the right hand, while motor power in both hands was very low, right extremities feeling colder than left, and it was noticed for the first time that patient spoke badly, the tongue being more difficult to move as the patient expressed it.

On July 1st there was converging nystagmus, the right angle of the mouth was lower than the left, and guttural sounds were difficult to produce. On the 2nd the symptoms were more aggravated, the tongue more difficult, and the power of the ileft ileg reduced, the flickering before the eyes increased, and the upward movement of the ball limited. On this date all the cerebral nerves were tested. The first was normal; the second: objects swimming with letters in reading; third and fourth: left lids contracted bulbi convergent, but the converging nystagmus gone, except when looking to the extreme left or right; fifth, sixth and seventh nerves of face almost normal, except left slightly below, while tactile and pinching were normal; the changes in the eighth were nil, but those on the ninth, tenth, eleventh and twelfth were protrusion of the tongue, fibrillary contractions in the left side, no disturbance in taste, uvula drawn towards right, left side of buccal vault loose, while left gums are reduced in innervation.

On July 4th, right facial paresis. On the 5th, there was left facial paresis and the right had disappeared. Subjectively there was a feeling of deafness and loss of sensation in the left side of the face; fundus normal, paresis in right arm, but no shaking or ataxia.

but no shaking or ataxia.

On the 6th, the difficulty of speech returned, the tongue being drawn towards the right, movement towards left being difficult, with dyspnæa.

On 7th, nystagmus bad left side of face, and

right arm and leg paralysed.

8th.—Power of speech still worse, Singultus, pulse 12), tachycardia, left arm free and grasp of hand strong, but left leg paralysed, right arm powerless, right leg paralysed, but pelvis resisting, and patellar reflex in both legs active as well as the Achilles reflex. The Babinski test was

positive on both sides, but no clonus. The cremaster muscles had no reflex. The sensibility of the right thigh was lost for tactile and pricking, while in both upper extremities this was undisturbed.

10th.—Both eyes follow the finger from right to left, but not without nystagmus contraction suddenly after returning to the middle line. The fundus was still normal, but the skin had assumed an icteric colour.

On the 11th he died. The clinical diagnosis was expressed as:—"Encephalitis multiplex, præcipue pontis, myelitis disseminata."

The post-mortem was conducted by Prof. Paltauf the following day: Medium size, well built and muscular, although emaciated, and pale in appearance. The cranium was 17 centimetres = 6.8 inch in length and 15 = 6 inch broad. and strong. Inner surface smooth, red, covered with loose clots and fluid blood. Meninges on convex and basal surfaces have veins congested with brain substance soft and moderately filled with blood. The cortex reddish, ventricles not enlarged, but the subependymal vein distended at a point where it falls into the vena terminalis. The basal ganglia red, but no pathological change to be discovered. A horizontal section in front of the quadrigemina passed through a red centre in the right peduncle, 4 millimetres wide, and depressed. The substance was friable and soft, which was also true of the medulla oblongata, particularly the grey substance. The floor of the fourth ventricle was greatly depressed. The left olive body in the region of the pyramidal had a narrow quadrilateral appearance with a very small centre of grey matter, with a similar yellow colour in the right restiform body. At the pyramidal crossing on the right side anteriorly was found another circumscribed reddish-grey centre with a yellow nucleus which extended to the anterior horn of the cord. In the upper part of the cervical region the central part of the posterior column was similarly affected, this red centre extending to the third and fourth cervical nerves; anteriorly on the right side this red centre had an oval, reddish-grey sunken appearance. Externally on the left side in the lateral column the same red centres could be found, but the surroundings more swollen. In the lower part of the cervical region in the right anterior column was found a soft greyish centre, ill-defined, but extending down into the dorsal region with great swelling and extending a reddish condition to the posterior column.

Macroscopic investigation gave no further information, but there were present extensive bronchitis, broncho-pneumonia, particularly in the right apex; in lower lobes thrombosis with pleurisy in right side.

The histological results were still more interesting. The peripheral nerves were taken first and coloured with Weigert's solution, but nothing worth recording was found. The longitudinal sections were not normal. With Marchi's solution streaks of osmium and dark grey colourations were present. At these parts the nerves were thin, though the centre of Schwann was increased and associated with Eltzholz bodies.

The spinal cord was different. Some of the segments were quite free, while others were badly damaged, the lumbar region alone escaping, but the cervical and dorsal were the seat of the principal morbid changes, although no localised

centre could be chosen as primary, both anterior and posterior being involved in the general destruction. These centres varied from the size of a pin's head to the area of the entire section. These centres were of all shapes, round, oval and wedge, the latter occurring mostly on the surface of the cord. No secondary degeneration was present in the lumbar region. The pia mater was perivas-cular and thickened, but the ganglionic cells were unchanged.

The principal lesion in the spinal cord was about the upper part of the dorsal region. Portions removed with the gouge and coloured with Weigert's solution showed loose fibres in a transitory condition, while in the centre of these local changes a small portion of debris which, when treated with Hæmalaum, had the appearance of small, round cells, having the character of perivascular round cells with several nuclei. The cells were found along the arteria spinalis ventralis and even into the sulcus longitudinalis ventralis. neighbourhood of these centres the axis cylinder was swollen with œdema, but no hæmorrhage was present. At these parts in the cord the glia or ependyma was increased in cellular consistency, but not in fibrous. In the middle of the dorsal region where these centres were absent, the pia mater was considerably thickened, and perivascular, which was equally true of the lumbar region. We thus distinguished two different kinds of centre in the upper part of the dorsal region, viz., those of a simple round cell character, and those of a granular character, the latter, when coloured, with Weigert, had fine shadows as if containing fine granules of myelin. In the midst of one of these centres a few fibres were always to be found which, when cut, showed the axis cylinder lying loose in the sheath.

It should be noted that sclerosis in the true meaning of the term was not present; on the contrary, there was a profusion of perivascular round-cell infiltration, these round cells having a double character, one with a distinct nucleus and little protoplasm like lymphocytes, the other having an oval nucleus with a normal amount of plasma, but granular. In the older centres of the cervical region the same appearance prevailed, and Marchi's preparations negatived all secondary degeneration, although in several a few fat cells

were present.

In the medulla oblongata a large triangular centre with the base towards the periphery, involving the pyramids and olive nuclei, with a smaller centre on the dorsal side which affected the fifth root, were found. When we consider the vascular supply of these centres and the surrounding of these vessels with round cells, which for the most part are lymphatic in character, more light may be thrown on the proximate cause of the disease. We must also remember that leucocytes are also present, but the true plasma cell is always absent. Secondary degeneration is absent here also as in the spine. but the infiltration around the centre is absent, while the glia or ependyma cells are pigmented, which on the outer margin form a network. On the dorsal side the morbid changes were more extensive, but the disconnection was marked. In some of these centres a characteristic distinction of age could be discerned, the older by the perfect absence of the granular cells and cloudy appearance, and the later by the profusion of typical fatty granulations. This difference

could be observed in the Weigert preparations as easily as in Marchi's preparations. This same process of degeneration was as marked in the posterior roots, but in the pons the centres were smaller, particularly near the lower part. One point might be noticed that no pathological change could be observed in the facial centre; in the cortex, however, the changes were in two directions, the first in the usual form, the second an irregular thickening and diminution of the fibres without any real distinguishing centre. Those in their earlier stage had light and dark streaks in their substance.

When we consider the clinical picture of the disease the relatively acute form is dominant. but the premonitory signs are wanting. We find at the beginning the sensibility disturbed and anæsthesia present, which is an unusual circumstance in the disease. It was eminently progressive from the first, and in spite of the number of phenomena no remissions could be observed. The disturbance of the bladder is another symptom unusual in the disease, although the multiplicity of centres may have caused the disturbance, being located in the brain as well as the spinal cord. Charcot's symptomatic trias had only the nystagmus present

As the speech was in no way affected and the bulbar type scarcely noticeable, on the other hand, Strümpll's initial symptom of skin and cremaster reflex were distinctly pronounced.

Again from first to last the whole process was non-febrile, which is often met with in acute multiple sclerosis.

The same reasoning is true of the pathological anatomy and agrees with Marburg's investigations that a relation exists between the morbid no sign of glia formation was present, but a profusion of granular cells existed, which is an important factor to remember. Notwithstanding the wide area affected no trace of secondary degeneration was present, but in the older centres the characteristic signs of sclerosis were present, and not infrequently old and recent centres were indistinguishably united or difficult to isolate from the sclerotic and granular cells lying close to one another. This approximation has led to different theories, Marburg assuming that the process is a disseminated chronic encephalomyelitis, with which Müller concurs that the secondary multiple sclerosis cannot be distinguished from the primary lesion. Völsch and Schobs do not go so far as this, and think there

is a distinction, placing the sclerosis as an endogenous process peculiar to the disease by the deposition of glia or ependyma.

In the case just recorded we have seen that the vessels are relatively little affected, which is the usual history given in all acute multiple scleroses. Marburg makes use of this circumstance for the rapid growth of the glia. It is well known that in cicatrices after hæmorrhage or encephalitis the injuring of the walls of the vessels leads to a general ischæmia and thus hinders the active proliferation of the glia, which is never present in multiple sclerosis. In the latter the glia is injured, while the parenchyma and nerve sheaths are destroyed; the vessels are found to be intact and the nutrition of the parts maintained, which assist the rapid repair of the glia and form a substitute for the parenchyma. It must be always remembered that the axis cylinder

in the morbid centre is found intact, which may also assist in the increase of the glia and sub-

sequent repair.

As to the ætiology of the disease little can be said, and on it this case throws no light. Infection may have had some part in the origin of the morbid change, as the patient had erysipelas four years ago, and thus induced the morbid process by meta-infection.

# SOME ENLARGEMENTS OF THE KIDNEY.

By L. G. GUNN, M.D., F.R.C.S.I.,

Surgeon to the Adelaide Hospital.

GENTLEMEN,—I have to-day three cases that may be, with profit, seen together; all are renal cases; two present typical symptoms and are easy to diagnose; one is difficult, so difficult that the diagnosis was not correctly made until the case had been operated upon.

The first case is this girl, æt. 6. For five months past she has had attacks of pain in the right side of her abdomen; these attacks have been associated with vomiting and with frequency in passing water; she has lost flesh, looks pale, and has an elder brother who suffers from tuberculosis. Such

is her story, as related by her mother.

The child has been in hospital just ten days; during this time she has had two attacks of pain; one only lasted a few hours, the other, a severe one, lasted for nearly two days, and was associated

with a good deal of vomiting.

On admission her urine was examined-you see it was normal and free from any sediment; with the onset of each attack it became scanty, loaded with urates, and passed very often in small quantities. As each attack passed off, an abundant flow of pale-coloured urine took place; the frequency continued, but now with each act of micturition 6 to 8 ozs. of this pale urine were passed; it had a sp. gr. of 1008, and showed a faint trace of albumin. If you examine the child's abdomen now you can all readily feel a smooth tumour, lying in and below the position normally occupied by the right kidney. The tumour is painless; the tumour is smooth; it moves freely up and down with respiration; you cannot push it up under cover of the liver.

Examining this tumour during an attack, I noticed that it was painful; both lumbar group and the rectus muscle on the right side were rigid. In spite of this rigidity, it could be easily felt that the tumour had increased considerably in size; with the diminution of the attack and the profuse flow of urine the enlargement slowly subsided to

the size you see it to-day.

Such a train of symptoms pointed clearly to the condition here being intermittent hydronephrosis of the right kidney. What may cause this obstruc-tion to the flow of urine:—(a) Undue mobility of the kidney with kinking of the ureter; this can hardly be the case here, for there is no increased movement of the kidney. (b) The presence of a small calculus in the ureter; two excellent radio-graphs of the kidney and ureter, taken for me by Dr. Harvey, fail to show any shadow suggestive of a calculus. (c) Congenital narrowing of the ureter; this does not, as a rule, give rise to such markedly intermittent hydronephrosis; is usually bilateral, and shows itself much earlier in life. (d) Spasm of the ureter has been suggested in cases where no apparent mechanical obstruction can be found at the operation, or where there is

no faulty opening from the pelvis of the kidney into the ureter; sometimes the ureter enters the pelvis at an acute angle, making a somewhat valvular opening through which the urine may at

times fail to pass.

I suspect that one or other of these two latter to be the cause of the obstruction in this case. treatment: expose the kidney and ureter; obvious and well-marked obstruction exists, rectify this fault; if the cause of the obstruction is at all indefinite, then it is far better to remove the kidney. Plastic operations very frequently are followed by a urinary fistula, which can only be cured by a nephrectomy, and are seldom justifiable unless there is doubt as to the soundness of the remaining kidney. (a)

The second case I call your attention to is this young man. His symptoms are entirely bladder symptoms. He has pain on passing water, especially at the end of micturition; this pain is felt chiefly at the end of the penis, but it is a referred pain originating at the trigone, and felt, as it so commonly is, at the end of the penis. has frequency, both by night and by day. He passes water every hour, or oftener; if he tries to hold it longer acute pain comes on, compelling him to empty his bladder. This means acute inflammation in the bladder, or possibly ulceration. We look now at his urine and find it acid, sp. gr. 1015; it has a heavy deposit of pus; through this pus are streaks of blood. The microscopic examination of this sediment clears up the diagnosis of this case, for tubercle bacilli are found in numbers among the pus cells. Primary tubercle of the bladder hardly ever occurs; it is, however, often secondary to infection of other parts of the genitourinary tract. I have examined both testes, seminal vesicles and prostate, but in none have I found any sign of tuberculous infection. I want you all to palpate his kidneys; you will find his left kidney is more than double its normal size, but is mobile and entirely free from pain. He has had no symptom calling his attention to his kidney, and until it was discovered here the patient was quite unaware that he had anything wrong there. the bladder infection not occurred, the disease might have gone on for months without being recognised as a cause for his failing health. cystoscopic examination of the bladder revealed some tuberculous ulceration about the mouth of the left ureter; the ureter itself is gaping and retracted; from it pus is flowing. The first two appearances point to extensive mischief in the pelvis of the kidney. Two days ago I passed a catheter into the right ureter and drew off some 2 ozs. of urine; this proved to be normal in every respect. Under these circumstances the treatment indicated is removal of the infected kidney, to be followed by irrigation of the bladder twice daily with warm carbolic lotion of the strength of 1 in 150, and this treatment will be combined with small doses of tuberculin, about 1-2,000 mgr., given once a week. (b)

The third and last case is this woman, æt. 61. Three months ago she was sent in as an acute case of appendicitis. She had then a normal morning temperature, but each evening it rose to about 1010 She had constipation, a furred tongue, and both looked and felt very ill indeed. On examining her

<sup>(</sup>a) This child was operated on three days later. A hydronephrotic kidney was found, with no definite narrowing of the ureter at the point of apparent obstruction. Mr. Gunn accordingly removed the kidney. The child was sent home well three weeks later.

(b) The following week the kidney was removed without difficulty, and proved to be extensively infected with tubercle. Two months later the boy could hold his water for three hours and the urine was almost free from pus. No tubercle bacilli could be found.

abdomen we could both see and feel a swelling in the right side of the abdomen. The middle of this tumour was at the level of the umbilicus; it was very tender to handle, it could move a little both up and down and from side to side; its position and mobility made me think that this was not an appendix abscess, but a solid tumour of the upper part of the cæcum, probably a carcinoma. With enemata and rest in bed the tenderness gradually left the side and the temperature came down to normal; the size of the tumour did not diminish. Several examinations of her urine showed it to be quite normal. I could not satisfy myself that I felt the kidney on either side. I thought if the swelling was a carcinoma of the cæcum it might be removed, and with this idea opened her abdomen through this incision which you see here at the outer side of the sheath of the rectus. It was at once apparent that the growth was retro-peritoneal, the ascending colon passing in front of it, and being somewhat flattened by the pressure on its posterior wall. There had been, I suspect, some fæcal lodgment in the cæcum, and this had possibly caused the pain and fever. The tumour was then, as you can feel it now, about the size of a goose's egg, and somewhat the same shape, attached firmly to the lower pole of the kidney. It felt on palpation like a tense cyst with thick walls. Now, believe it is very rarely justifiable to remove one kidney without knowing the functional condition of the other, so in this case I closed the abdomen without doing anything further. It remained still uncertain what the nature of this tumour was. I have already shown you two enlarged kidneys, one hydronephrotic, the other tuberculous. Remember that her certainly neither of these. Remember that her urine contained no trace of pus, nor was there any history of hæmaturia; this is of great importance, for in the great majority of cases of solid tumour of the kidney, be it carcinoma, sarcoma, or adenoma, the first symptom is blood passing in the urine. The absence of hæmaturia was against this being a solid tumour. An X-ray photograph showed no shadows, so a stone could in all probability be excluded. The commoner cysts in connection with the kidney are hydatid, congenital cystic disease, and simple cysts. The urine was repeatedly examined for hydatid hooklets, but without finding any. In congenital cystic disease the whole kidney is affected, and the cysts are multiple. In this case the tumour was smooth on the surface, and probably single. We must, then, class this case as one of simple cyst growing from the lower end of the The question of treatment was a somekidney. what anxious one. The old lady, as you can see, is by no means strong, and nephrectomy is always a serious operation, with, in her case, a risk so definite that I would not advise her to have it done unless the removal of this tumour was of vital importance to her. A catheter passed into the right ureter showed that the two kidneys were acting equally, and that the urine was normal from both; this further confirmed me in the opinion that the tumour was a simple cystic one, and doing little or no damage to the patient. The woman has been under observation for the past three months; during this time she has put on nearly a stone in weight, and the tumour has not increased in size. I hope to keep her under observation for at least another three months, and if during this period the tumour becomes larger, or hæmaturia occurs, I shall advise the patient to have the tumour removed.

There are many lessons to be learned from these three cases. Possibly the most important is that extensive growth may take place in a kidney without any abnormality showing itself in the urine; a normal urine is therefore no proof that the patient has normal kidneys. Another important point is the freedom from pain. Both in cases 2 and 3 pain the freedom from pain. Both in Cases 2 and 3 pain the kidney there was no pain until the growth had infiltrated neighbouring tissues. The last point I would draw your attention to is, that the use of the ureteral catheter is essential for the successful treatment of such cases.

### **OPERATING THEATRES.**

GUY'S HOSPITAL

Congenital Enlargement of the Large Bowel—Removal of Volvulus of the Sigmoid, and Later Rectum.—Mr. W. Arbuthnot Lane operated on a girl, æt. 14, who had suffered from severe abdominal pain and constipation from birth, for which she had been treated medically by massage, etc. This condition became very critical in 1904, when he removed a huge volvulus of the sigmoid which filled and distended the abdomen. The junction was effected between the ends of the gut at the base of the volvulus by establishing direct continuity of the intestine. This corresponded to the upper part of the rectum. The rest of the large bowel was very dilated indeed.

The patient made excellent progress for a time, but

The patient made excellent progress for a time, but in February, 1908, owing to the pain, distension, and auto-intoxication, Mr. Lane opened the abdomen with the object of enlarging the junction which he thought might have contracted. The aperture of communication readily admitted three or four fingers, and it was obvious that the dilated large bowel was unable to evacuate its contents. There was no obstruction in the ordinary sense. By irrigation through a long tube, by massage and other means, some temporary alleviation of symptoms was obtained. In January, 1909, the auto-intoxication, pain, and distension had become so aggravated that he determined to remove the big bowel, although the condition of the patient appeared such as to render this operation exceedingly dangerous. On the other hand it was apparent that the end could not be long postponed unless the auto-intoxication was relieved. The child being under ether, about four pints of normal saline solution were introduced beneath the skin during the whole period of anæsthesia, such fluid being run in rapidly before the operation was commenced. The enormously distended large bowel, full of fæcal matter, was then gradually removed from the abdomen; the rectum was divided at its upper limit and closed, as was also the ileum, about four inches from its termination.

The end of the ileum was connected by a lateral anastomosis with the stump of the rectum, it being necessary to employ cleft palate needles and holder for the purpose, owing to the fact that only a small portion of the rectum covered by peritoneum was left after its ligature and closure. The child was much collapsed by the operation, but she improved slowly. On the fourth day her bowels acted, and continued to do so at intervals. Her pulse, which was very rapid before the operation, again became rapid, and continued so. She died after a prolonged struggle for life, lasting nineteen days.

Mr. Lane said that but for the use of large quantities of salt and water subcutaneously, both before and during the operation, it would have been impossible to have carried it through successfully owing to the very feeble condition of the patient. He had endeavoured to obtain from some relative or friend a direct transfusion of blood, but had been unsuccessful. It was very possible, he thought, that it might have saved the child's life. The advantages afforded by the immediate introduction of a large quantity of normal saline into the circulation, he pointed out, are most striking, the increase in the blood pressure reducing shock to a minimum, and preventing any vomiting. By the use of this procedure the risk attending the removal of the large bowel has been very materially reduced.

The explanation of the modus operandi of this is rendered perfectly clear by Dr. Crile's experiments on Though the condition of the large bowel in these cases differs altogether from those present in ordinary chronic intestinal stasis is that in the ormer there is considerable hypertrophy of the muscular coat of the dilated bowel, and that the bowel cannot be satisfactorily emptied by purges, yet the symptoms are very similar, namely, pain and auto-intoxication.

### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

MEETING HELD FRIDAY, MAY 14TH, 1909.

The President, Sir THOMAS BARLOW, Bart., K.C.V.O., in the Chair.

Dr. T. STACEY WILSON exhibited three

COLOURED PROJECTION DRAWINGS OF THE BRAIN.

showing the relation which the internal structures would be seen to have to the convolutions, if the brain were transparent. These had been prepared by photographing serial sections, cut through a carefully graphing serial sections, cut through a carerumy hardened brain, and afterwards drawn to scale, and were designed to assist the surgeon in cerebral

Dr. ALEXANDER FLEMING gave a demonstration of a SIMPLE METHOD OF SERUM DIAGNOSIS OF SYPHILIS by the "Complement Deviation" Method.

This differed from Wassermann's original method in

the following respects:

(1) An alcoholic extract of normal heart muscle was used instead of a saline extract of syphilitic liver.

(2) The natural hæmolytic power of human serum for sheep's corpuscles was made use of, thus doing away with the necessity for the hæmolytic serum of a rabbit immunised against sheep's corpuscles and the guinea-pig's serum (complement).

(3) The amount of blood which can be collected in

an ordinary blood-capsule furnished an ample supply

of serum for the test.

As the outcome of the examination of a large number of cases of undoubted syphilis, both acquired and congenital, he had found that a positive result

was given in 96 per cent.
Dr. McIntosh asked how many controls had been used, as he was surprised at the high percentage of positive results obtained, which was higher than that obtained by Wassermann. He had himself found that, by the original method, a considerable number of cases of aortic aneurysm gave a positive result.

Dr. Fleming, in reply, stated that he had used over 300 controls, with a positive result in only 10 per cent. This was due to the fact that the blood of about 10 per cent. of normal individuals contained no hæmolytic power for sheep's corpuscles, a difficulty which might be got over by other means.

Dr. FREDERICK SPICER showed a case of

PARALYSIS OF THE RIGHT SPINAL ACCESSORY NERVE.

It was that of a traveller, æt. 32, who had always enjoyed good health until the middle of January last, when he complained of sore throat, weakness of voice, pains on the right side of the head, right shoulder and right arm. He was found to have paralysis of the right vocal cord, the right side of the soft palate, the right sterno-mastoid, and the right trapezius. There was very considerable wasting of the muscles, with marked drooping of the right shoulder. He had had influenza some four months previously; there was

no history of syphilis or injury.

Dr. F. E. BATTEN said that the patient showed one sign, which he thought threw some light on the nature of the case, namely, Argyll-Robertson pupils. He thought that the symptoms suggested an anomalous

of tabes.

Mr. Walter G. Spencer showed a

CASE AFTER REDUCTION OF AN OLD SUBCORACOID DISLOCA-TION OF THE RIGHT SHOULDER, COMPLICATED BY FRACTURE OF THE UPPER THIRD OF THE HUMERUS, BY EXCAVATING THE GLENOID CAVITY POSTERIOR INTERMUSCULAR INCISION.

An engineer, æt. 43, was riding a motor cycle when a collision occurred; he had received severe injuries—viz., fracture of the base of the skull with concussion, fractured ribs, dislocation of the head of the right humerus, oblique fracture of the upper third of the shaft of the right humerus, and widespread ecchy-moses about the right shoulder. The fracture of the humerus had slowly united with overlapping of the fragments to the extent of about two inches. When first seen, the humerus was fixed to the scapula, which could be moved very little, and the oblique union of the humerus was not firm. His arm could now be raised to the vertical without moving the scapula much more than normal. He could swing on a horizontal bar and use a 4 lb. dumb-bell. He had returned to work, and each week had shown increasing ability to carry out overhand movements.

Dr. Finzi showed a case of INOPERABLE RECURRENT SCIRRHUS OF THE BREAST UNDER TREATMENT BY RADIUM.

The growth had been present for eight years, and the breast had been removed three years ago. It had recurred, and been considerably improved by X-ray treatment, but, owing to the patient's failure to attend for some weeks, the growth had again become more rapid and extensive. From March 10th, 5 cgm. of radium filtered through a silver tube 0.6 mm. thickness and mm. thickness of india-rubber had been applied over the large mass for fifty-three hours, the position of the tube being altered once. On March 12th a dose of 41 hours was commenced in the axilla. The radium used was the pure bromide, and was contained in a little glass tube within the silver tube. The tumour by April 2nd, 1909, had almost disappeared except for a little thickening between the two places where the application had been made. This had proved to be a definite nodule, and a dose of 26 hours, with filters of 0.6 mm. silver and 1 mm. lead, and six hours with 0.6 mm. silver was given, starting on April 29th, 1909.

Also a case of EPITHELIOMA OF THE LOWER LIP UNDER TREATMENT BY RADIUM.

This had started as a pimple, which gradually got larger and became crusted over, and had been growing for 15 or 16 years. The rapidity of the growth had considerably increased for the last eight or ten months. There were enlarged glands under the jaw on both sides, but larger on the left than the right. Treatment by radium was started on March 31st. Epilation was noticed on the neck about April 20th, and on the left side of the upper lip on May 5th. Considerable improvement resulted both in the growth and the glands.

Mr. RICKMAN GODLEE asked whether in such cases

radium should be applied in a little tube or in various

appliances, as was being done in Paris.

Mr. WALTER G. SPENCER said that he hoped that the case of epithelioma of the tongue would receive ordinary surgical treatment. He had seen a somewhat similar case of epithelioma of the tongue which had been treated in Paris, and had developed very large cystic glands, encapsuled by malignant epitheliomatous growth. He considered that the treatment had made that case much worse.

Mr. GORDON WATSON said that the growth had certainly become smaller, as shown by careful measurements, and that now any operation would cause less mutilation than would have been necessary when the patient was first admitted to hospital.

Dr. A. HOWARD PIRIE said that if radium was spread

out too much it often lost its power.

Mr. PEARCE GOULD said that the exhibition of these cases was obviously only preliminary. They were both cases of a chronic type. He thought that Dr. Finzi had under-estimated the severity of the lesion in the second case. Any diminution in the prominence of the growth might be due to reduction in the lip around it. He did not think that there was any actual cicatrisation of the ulcer.

Dr. E. H. Shaw said that from the microscopical appearances he thought the treatment had caused no change in the carcinoma cells, but an increase in the round-celled exudation. There was no true scar formation on the surface of the ulcer.

Dr. Finzi, in reply, said that for deeper structures a small tube was necessary, but the radium could be more spread out for cutaneous cases. The decrease in the growth could not be due to diminution in the blood supply, because that was more than formerly. There was no true cicatrisation, but this did not occur with radium, for by it a film was produced and healing occurred underneath it.

Dr. Finzi also showed a case of

ARTHRITIS TREATED BY IODINE-LITHIUM IONISATION.
The patient was kicked on the left knee on May 8th,
1907. Synovitis followed. In July, 1908, the tissues
around the knee and the synovial membrane were much There was also considerable grating in the thickened. point, and he was unable to walk without a stick.

From Auust 7th to September 21st he had been treated
by iodine-lithium ionisation. This soon relieved the
pain and other symptoms. Before the treatment was
stopped the patient walked thirty miles, and had subsequently come in second in a running race. September 21st, 1908, there was great diminution in the thickening round the knee, and it was normal.

Mr. V. WARREN Low showed a case of

PNEUMOCOCCAL CYSTITIS AND ARTHRITIS. The patient was a young man, who had been admitted to hospital on December 15th, 1908. Cystoscopic examination had revealed the presence of cystitis, accompanied by numerous superficial ulcers and hæmorrhages of the bladder mucous membrane. A pure culture of pneumococcus had been obtained from the urine. On December 28th arthritis of the knee-joints developed, and the clear fluid which was removed yielded a pure culture of the same organism. Other joints which subsequently became affected were the right elbow, right fourth metacarpo-phalangeal, left right elbow, right fourth metacarpo-phalangeal, left elbow and left wrist. Only once was the temperature above 101° F., and the patient never appeared to be seriously ill. He was discharged to a convalescent home on February 24th, and had quite recovered. His treatment had been by vaccine therapy, using his own organism by urotropin, sammetto, and for a short time by Bier's treatment for the joints.

Mr. Sidney Boyd showed a case of SPRENGEL'S DEFORMITY OF THE SHOULDER AND HIRSCH-SPRUNG'S DISEASE, WITH DEFINITE RECTAL OBSTRUCTION.

The patient was a boy, æt. 9. Deformity of the left shoulder had been noticed since 3. The left scapula was higher and smaller than the right. It was freely movable, but movements of the shoulder-joint were somewhat limited. The boy had been constipated since birth, and on rectal examination a tight ring could be felt just above the sphincter. The colon was could be felt just above the sphincter. The colgreatly dilated, as shown by X-rays.

Dr. F. PARKES WEBER showed the case of a

WOMAN THREE YEARS AFTER OMENTOPEXY AND PERITONEAL DRAINAGE FOR CHRONIC ASCITES CONNECTED WITH HEPATIC CIRRHOSIS.

The liver was hard and large, reaching to the level of the umbilicus. Tapping had been required five times in the fourteen months preceding the operation. After the operation, which was performed on December 1st, 1905, the abdomen soon filled again and had to be tapped four times in the next three months. Two more operations had been performed, one to stitch more omentum to the abdominal wall, the other to give continuous drainage. The last tapping she had required was in January, 1907, and her general condition had greatly improved.

Dr. DE HAVILLAND HALL and Mr. W. E. SPENCER

showed a case of

SPLENECTOMY FOR SPLENIC ANÆMIA The patient was a girl, æt. 84, who was admitted to hospital for enlargement of the spleen and liver. had increased somewhat under observation until it reached forwards to the umbilicus and downwards to the iliac crest. There had been leucopenia. When exhibited the patient had greatly improved, and there was nothing noticeable except anæmia. The liver exhibited the patient had greatly minds. The liver was nothing noticeable except anæmia. The liver weighed 23 lb., and showed no microscopic change, except engorgement of the blood vessels.

HERNIA OF THE TIBIALIS ANTICUS MUSCLE. The patient, a man, æt. 40, had fallen and twisted his leg eight months ago, when a girder fell across his right foot. The rent in the deep fascia was due to irregular or sudden contraction of the subjacent muscle. The situation of the hernia would appear to

be unique.
Mr. W. H. BATTLE showed a case of

TUBERCULOUS KNEE, which had been dislocated, contracted and ankylosed. A Horfftiche's appliance had been used for three years, with the result that the dislocation had been overcome and fair movement obtained.

Dr. Poynton and Mr. Trotter showed a case of CARDIOLYSIS,

and read a paper on the subject. The patient, a boy, æt. 16, had been admitted into hospital under Sir Thomas Barlow, in August, 1908, with severe symptoms which were considered to be due to an adherent periwanter were considered to be the to an adherent peri-cardium, with mediastinitis, left pleurisy, and peri-hepatitis. He improved considerably after rest and was discharged, but was readmitted on September 21st, under Dr. Poynton, with the history that his symptoms had at once returned on leaving the hospital. At rest in bed he was much better, but on the slightest exertion ædema and breathlessness at once appeared. Cardiolysis was performed by Mr Trotter on October 5th, 1908. A semi-circular flap was marked out in the præcordial region, and was reflected up-wards. It included all the structures anterior to the ribs. The fourth and fifth ribs moved most with the cardiac movements, and between 3 and 4 inches of each were removed, the periosteum being left behind. The pericardium was found thickened and adherent to the chest wall over the region exposed. After removal of the ribs, the structures over the heart accommodated themselves far more easily to the cardiac movements. The flaps were replaced and the wound completely At the present time the operation had been justified by the result, for the patient could now go for a walk extending over half-an-hour, and in the evening there was only slight pitting over the ankles. The heart, liver, and spleen had all diminished in size.

The operation was first suggested by Brauer, and put into practice by Petersen in 1902. The idea was that in certain cases in which the heart is embarrassed by fixation to surrounding parts, a considerable amount of this overloading of the heart's action could be got rid of by rendering the præcordial part of the chest wall more flexible than normal by removing its bony and cartilaginous framework. No extensive separation of adhesions was suggested, and it is obvious that such would be dangerous. In the first obvious that such would be dangerous. place the subjects were unsuitable for anæsthetics, and the risk of tearing the heart or pleura was great. a review in 1908 a total of 17 cases had been collected; no death was recorded, and the results appeared to be very good. The most suitable cases were those in which the heart was just inadequate for active life. The chief difference of opinion lay in the advisability of removing the periosteum or allowing it to remain.

Dr. ALEXANDER MORISON said that Mr. Stabb had removed for him a rib over a sarcomatous growth to relieve pressure, leaving the periosteum, and the rib had been entirely renewed. Last year, in another case, parts of the fourth and fifth ribs and their periosteum had been removed for a ortic disease and hypertrophied The patient had been greatly relieved of pain. In a third case the operation had been done adherent pericardium, and again the periosteum had been removed. This had been very difficult, and the pleura was torn with the removal of each piece of rib. The patient had greatly improved, but died later of fresh pericarditis. He thought that it was almost inevitable that in the case shown the rib would again grow and the heart again be incarcerated.

The PRESIDENT said that there was no doubt but that the boy was much better. In such cases the jugular veins were often very large, and this had now disappeared.

Mr. RICKMAN GODLEE said it would be more important to remove the perichondrium than the periosteum.

Sir JOHN BROADBENT said that often in such cases

the right ventricle showed signs of failure which could not be relieved by this operation.

Dr. W. EWART said he would like to know whether the kidneys and liver showed improvement also, and suggested skilfully arranged physical treatment by rest

and exercise.

Mr. A. E. BARKER said that some form of cautery might be used to destroy the bone-forming capacity

of the periosteum.

Mr. TROTTER, in reply, said that improvement was continuously progressive. He thought that the amount of regeneration of bone depended much on the local conditions around the periosteum. He thought that Dr. Morison's cases went to show that the operation, where it had been removed, was very difficult, and that the pleura was often opened. In any case only a small posterior strip was left, much of which could be readily removed, but no formal attempt to remove it all should be made. The regeneration was usually only slight.

### EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

### MEETING HELD MAY 5TH, 1909.

The President, Dr. JAMES RITCHIE, in the Chair.

DR. BYROM BRAMWELL showed (1) A Case of Scleroderma of the Hands and Forearm under treatment with fibrolysin. The patient was by occupation a stonemason; in Dr. Bramwell's experience scleroderma was not uncommon in this trade. Under injections of fibrolysin considerable improvement had taken place. A notable point in connection with the use of the remedy was that the injections produced a febrile reaction, was that the injections produced a februe reaction, which appeared to be quite independent of any septic contamination. He had observed a similar reaction in some, but not all, other cases of disease treated with the drug. (2) A Case of functional nervous disease treated by isolation, Faradism, and the hypodermic injection of water. The patient was a child who had some months previously been bitten by a dog. The bits had healed perfectly but every day, at the hour at some months previously been bitten by a dog. The bite had healed perfectly, but every day, at the hour at which she had been bitten, the little girl complained of severe pain in the scar, and assumed the position she was in at the time she received the bite. She was told that she would soon be quite well, and that she would be isolated behind screens until her recovery. Under the influence of this energetic suggestion, and injections of water, isolation, and a milk diet the seizures very rapidly disappeared.

Dr. Walker showed (1) A Case of Acanthosis Nigricans in a woman. In many of the reported cases of this

in a woman. In many of the reported cases of this rare disease there was evidence of malignant disease of some of the internal organs. In the patient shown, however, this did not seem to be the case. The case was extremely typical of the condition; the occurrence was extremely typical of the condition; the occurrence of pigmentation very similar to that of Addison's disease was pointed out. (a) A Case of Pityriasis Rubra Pilaris. (3) A Case of Lichen Scrofulosorum. (4) A Case of Rapidly Advancing Tuberculous Ulceration of the Skin of the Thorax. (5) Cases of Lupus Treated by the Local Application of Tuberculin applied as a 5 per cent. ointment. This was rubbed in vigorously on four successive days and covered with a piece of lint. The result was a marked reaction, followed by lint. The result was a marked reaction, followed by selective sloughing of the tuberculous tissue. The results on the whole were extremely satisfactory. A point made was that in the case of small patches of lupus the reaction spread rather widely into the surrounding and apparently healthy skin, showing that it was also invaded by the process. This wide invasion of the surrounding skin appeared to be the principal reason why excision of a patch of lupus was so often

a failure.

Professor CAIRD showed (1) A man after ligature of the subclavian artery for axillary aneurysm. The third part of the subclavian was tied. At the operation it was remarked that on account of the upward displacement of the shoulder and the communicated pulsation it would not be difficult to mistake one of the cords of the brachial plexus for the artery. The only altera-tion in the circulation of the arm was a slight delay in the return of the normal colour when the parts were blanched by pressure.

(2) A patient after operation for internal strangulation. The symptoms were very acute, and simulated appendicitis, yet at the operation a band only partially constricting the small intestine was all that was found.

(3) A peculiar condition of the leg after passive congestion. The patient had had a condition of the left knee diagnosed as tuberculous, and for this Bier's treatment had been ordered. Anxious to carry out the treatment thoroughly, the patient had kept the bandage constantly applied for three days. constantly applied for three days. The result was to produce a permanent condition of elephantiasis. It was presumed to be due to some lymphatic obstruction, but the only definite change, apart from the elephantiasis,

the only definite change, apart from the elephantiasis, was a slight enlargement of the inguinal glands.

Mr. H. J. Stiles showed (1) A patient after pylorectomy for chronic ulcer of the stomach. Neither at the operation nor after the pyloric portion had been removed and split up was it possible to say whether the ulcer was simple or malignant. Microscopically the ulcer was found to have undergone malignant degeneration

(2) A patient after operation for extensive tuber-culous disease of the glands on both sides of the neck. Practically the whole of the glands had been cleared

Mr. STRUTHERS showed a baby, aged 17 months, which had received an injury to the head from a fall, and had been admitted to hospital in convulsions. On examination the child appeared to be dying; it was unconscious, with right-sided convulsions. A trephine opening was made over the left motor area and a good deal of cerebro-spinal fluid escaped. The fits at

once ceased, and the patient made a good recovery.

Mr. J. M. Cotterill demonstrated the use of
Burgess's instrument for irrigating the abdomen. The supposes a instrument for irrigating the abdomen. The instrument consists of a combined douche nozzle and syphon, and Mr. Cotterill commented on the easy way in which any part of the peritoneal cavity could be flushed out and left dry and clean by using it.

Mr. Cotterill also showed specimens of Hirschsprung's disease, tubercle and syphilis of the testicle, cancer of the penis, pigmented mole, tumour of the appendix etc.

appendix, etc.

Dr. ALEXANDER BRUCE showed (1) Multiple acute aortic aneurysms resulting from vegetative endarteritis.
(2) Acute hæmorrhage encephalitis. (3) Cystic tumour of the pituitary body which had caused bitemporal hemianopsia. (4) Large sarcoma of the pituitary

Mr. Stiles showed preparations removed from the two cases exhibited.

Dr. J. S. FRASER read a paper on the

HISTOLOGY OF ACCESSORY SINUS SUPPURATION. After describing the normal histology of the mucous membrane lining the cavities, he referred to the drain-age mechanism in normal and abnormal conditions, showing that the ciliary movements played an important part. He next discussed the histological changes in the mucous membrane in acute inflammatory conditions, in chronic catarrh, and in chronic suppuration, pointing out that the difference between chronic catarrh and suppuration was largely one of degree. Attention was also drawn to the relation between cedema of the various mucous membranes, polypoid swelling of the mucous membranes, and nasal polypi. In conclusion, stress was laid on the possibility of a more extended knowledge of the varying histological changes in such conditions affording a better basis for classification and treatment. The paper was illustrated by a number of lantern slides showing the points referred to.

### CORRESPONDENCE.

### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.
Berlin, May 16th, 1909.

In the Fortschr. d. Medizin, 8/09, Dr. Burckhardt, of

Dresden, discussed the
TREATMENT OF UMBILICAL HERNIA BY MEANS OF
PARAFFIN WAX. When the hernia persists, he says, beyond the second

year it is likely to become permanent. Independent of operative closure, treatment by strips of adhesive plaster is very generally made use of. This has the disadvantage, however, that it frequently causes eczema, which makes the child cry, still more raising the intraabdominal pressure. The pad with the elastic bandage is just as difficult to bear, and must be made use of for a long time before the hernia is permanently cured. By injections of paraffin, on the other hand, there is a possibility of closing the hernial aperture in the course of a few days.

After most careful disinfection of the hands and of the parts to be treated, the hernia is raised by two fingers of the left hand. The contents then recede from lateral compression. The right hand now introduces the needle, the tip of which is flexed, and has its exit opening on the side opposite to the flexure. It is introduced in such a way that the point is free in the hernial sac. Three to 4 cm. of paraffin are now introduced at a temperature of 65° C., when, the pressure of the left hand is relaxed so that the hernia feels to be as full as it was before. The part is now to be sprayed with ethyl chloride, and the needle withdrawn. The point of injection is now to be covered with a gauze pad, and fastened on with plaster. A circular plaster bandage kept on for a week ensures success. There is now a paraffin cap within the sac, which has solidified under the ether, by the bandage it is pressed into the shape of a plate, and completely prevents any further escape of the bowel. The irritation it now content leads to inflammators adhesion at the nack of causes leads to inflammatory adhesion at the neck of the sac.

On first attempts the mistake is often made of using too much paraffin, which makes the pad large and unsightly. The limit to this method is that the neck of the sac must not be more than r cm. in diameter; when larger than this, several sittings will be necessary to form a pad sufficiently large to keep back the bowel; this is especially the case when the rupture is associated with diastasis of the linea alba. No untoward complications have ever been met with in carrying out the procedure; if any paraffin escapes into the abdominal cavity, it solidifies quickly and does no harm. Only the so-called hard paraffin with a melting point of 54 c. should be made use of; it should be sterilised before use by being boiled in a closed vessel. The right temperature can be got by means of a dip thermometer, and the syringe and cannula must be kept in almost boiling water before use in order to prevent the sac must not be more than I cm. in diameter; when in almost boiling water before use in order to prevent solidification before the wax can be injected. Rubber coverings over the syringe do not do much good but prevent asepsis.

prevent asepsis.

The writer always operated in this way unless the walls of the hernia were too rigid and cicatricial, to allow fluid paraffin to be easily introduced. In such cases he uses a syringe with a rotatory piston, which will force out the paraffin under pressure, in the same way as ointment is forced out of a collapsible tube.

Children here the treatment ways wall

Children bore the treatment very well.

Soft paraffin, often mixed with vaseline, is dangerous on account of the liability to embolism. It also becomes absorbed, and is liable to wander, and act as a foreign body.

When hard paraffin is used, organisation takes place in the sense that the pad becomes surrounded by a hard mass of connective tissue. From this a largemeshed network of connective tissue partly divides the pad, but holds it firmly in place.

During the period of four years he failed to notice

any change in the pads so introduced.

any cnange in the pags so introduced.

PROTECTION FROM SMALL-POX IN PRUSSIA.

A note has recently been issued by the Prussian Ministry to the proprietors of warehouses in which rags are sorted and dealt with. It acknowledges that it would be difficult to carry out a wholesale revaccination order; that in the case of rags collected inland there would be very little danger of infection from them, that in the cases in which the rags come from a foreign source, and especially when they come from a foreign source, and especially when they come from the interior of Russia, there is considerable danger that those who are compelled to handle them may contract infection. This being so, it calls upon those superintending such warehouses to instruct their employees in the matter in a friendly way and to urge upon them the importance of re-vaccination. In cases

in which infection has been distinctly traceable to handling such rags the law with regard to such cases will be strictly carried out.

### AUSTRIA.

Vienna, May 16th, 1909.

ENDONASAL OPERATION FOR HYPOPHYSIS CEREBRI. At the Gelsellschaft der Aerzte, Hirsch gave a description of an operation which he recommends for the removal of a morbid pituitary body. After anæsthetising the internal parts of the nose he removes the middle turbinated bone, and then allows the part to rest a few days. After a short period he anæsthetises again and removes the posterior part of the ethmoid bone. Again a pause is made, with a longer interval before commencing the third time, on which occasion he removes the anterior wall of the pterygoid bone, making another pause before he opens the dura mater

and removes the morbid growth.

Hajek doubted the advantages to be obtained from this method, as the nose would tend to collapse after the operation. Again, the *technique* was so elaborate and the operation so protracted, while the access was so natter in the nasal channel that he doubted whether the operation could be satisfactorily performed at such a distance from the exterior. He considered this surgical method too circuitous and dangerous for general practice. Ranzi thought the objections covered the advantages, as the sella in the morbid condition lay further off than in the normal state, thus adding to the further off than in the normal state, thus adding to the difficulty, while the danger of meningitis was certainly greater. The cosmetic advantage in the endonasal operation was very questionable when compared with Hochenegg's method, which always gave satisfaction. Tandler asked if the optic nerve was not in greater danger, while Schüller commended this operation, as he had examined many of the results with the Röntgen had examined many of the results with the Röntgen rays and concluded they were more favourable than others. Moszowitz and others expressed their fear of inducing meningitis more readily by infection. Hirsch, in his reply, thought Hajek's fears were unfounded, as the opening he made into the base of the brain was very small, but sufficient to remove the hypophysis; but a small, but sufficient to remove the hypophysis; but a partial removal he found always gave favourable results. Again, the stage method had the advantage of not reducing the patient, as the bleeding was very slight and easily controlled. The fear of meningitis was no greater than in other operations. The danger of wounding the optic nerve was always great, under any circumstances, especially when the septum was thickened, but no greater than other surgical operations in rhinology. His statistics of infecting the meninges in rhinology. His statistics of infecting the meninges through the lamina cribrosa were no higher than other operations.

LUXATIO FEMORIS CENTRALIS. LUXATIO FEMORIS CENTRALIS.

Handek presented a case which required the Röntgen rays for diagnosis. The patient fell seven months ago from a window he was cleaning. After the accident the left side of the chest, left forearm, and left hip were injured, which kept him in bed three months. He had no great pain, but after getting out of bed he had a limp, caused by a shortening of 4 ctms. in the left leg. Measurement gave a shortening of 1 ctm. in the Rosa-Nelaton line, and 2 ctms. between symphysis and trochanter. Pressure on the trochanter major gave and trochanter. Pressure on the trochanter major gave no pain, and the leg was slightly adducted. The rays showed that the femur was intact, but the acetabulum had been injured and allowed the head of the bone to move forward and form a new depression, round which periosteum and bony structure had formed. It appears that the ascending ramus of the pubic bone had been fractured by the fall, which allowed the head of the femur to move forward into the fractured cavity.

### HUNGARY.

Budapest, May 16th, 1909.

AT the recent meeting of the Nagyvárad Medical Society, Dr. Révész Vilmos read a paper on the EXCRETION OF SALTS IN NEPHRITIS.

He said that if a healthy person is kept on a uniform diet for several weeks and then a certain amount of chlorides, phosphates and sulphates be given, these salts may be excreted in twenty-four to forty-eight hours, but occasionally the excretion may begin only in twenty-four to forty-eight hours, and last for three days more, even where there is no nephritis. He has studied this fact with regard to nephritis, and found that in cases without cedema, two types may be recognised as far as the chlorides are concerned. In one, the ingestion of a medium quantity of salt is followed by diuresis with a diminished percentage, in the other the percentage is constant and not influenced by the amount of urine. In uncompensated nephritis with cedema the percentage is frequently diminished if salt is given. There seems to be a distinct antagonism between chlorides and phosphates, for the latter are excreted most freely where the retention of chlorides in the system is greatest and vice versa. The same holds true for the sulphates. From a prognostic point of view, an increased excretion of chlorides in nephritis, after a period of retention, is a favourable sign, hence a diminished excretion, an unfavourable one. A prolonged increased discharge of phosphates will speak for a retention of chlorides. A drug, such as diuretin, which would wash the chlorides out of the system, would have a favourable influence upon the cedema were it not for the injurious effect upon the renal epithelium. Heart tonics are in place, as they help unloading the system of salt, but salt itself should be restricted in the diet. The so-called thirst cures do not rest upon a sound basis, since the retention of salt, and not that of water, is the primary cause of cedema. If saline intravenous or subcutaneous infusions should be necessary, in the course of the disease, they should be hypotonic, that is, should contain less than o.gr per cent. of salt.

The Biological Function of Calcium.

Dr. Mechwart found, in an investigation of the relation with calcium bears to the enzymotic process that results in the coagulation of the blood, that calcium is present in the ionic state, and that the amount of calcium-ion sufficient to bring about coagulation is very small, much less than the total quantity of calcium normally present in the blood. This hypothesis explains rationally a large number of phenomena relating to blood coagulation, namely, as follows:—(1) All the physical causes that diminish the degree of ionisation can produce incoagulability (cold, great molecular concentration). (2) All those reagents which, like the oxalates, fluorides, and alkaline carbonates, prevent coagulation by combining with the calcium in the blood, produce this result, when present even in very small doses. Upon the basis of his researches, Dr. Mechwart concludes that the coagulation of the blood requires the presence of ca-ion, whose concentration may vary between wide limits; this concentration has a minimum and maximum, below and above which respectively the blood remains indefinitely in a liquid state. The blood will not coagulate if by means of physical or chemical reagents the ca-ion is made to go beyond the above limits.

Asepsis in Catheterisation.

Dr. Kasper recommends an ideal lubricant for catheters and sounds. This consists of a mixture of glycerin, water, and tragacanth, together with mercury oxy-cyanate, I in 500. This does not irritate the urethra, renders the instruments very smooth and slippery, is readily soluble in water, and dissolves as soon as the instrument is inserted into the bladder, without obscuring the view through the cystoscope. In place of boric acid for washing out the bladder, he prefers mercury oxy-cyanate, I in 5,000. This is non-irritating, does not injure the instruments, and although not a strong antiseptic, is yet sufficient to inhibit the growth of microbes. His method is as sponges dipped in tincture of green soap, using each one for a minute. The instrument is then wrapped in a compress impregnated with the same material and kept in this until needed. Whatever parts can be removed are boiled for five minutes.

### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

ABERDEEN ROYAL INFIRMARY.—Dr. Angus Fraser, Physician to the Royal Infirmary, has intimated to the

directors his resignation, after a period of office extending to 38 years. In recognition of his services the directors have appointed him a Consulting Physician to the institution.

A New Species of Strophanthus.—Sir Thomas Fraser and Dr. Mackenzie have recently communicated to the Royal Society of Edinburgh some interesting researches on a new species of strophanthus strophanthus sarmentosus, used, like so many other plants of the same genus, as an arrow poison in Africa. The general action of the new drug on the circulatory organs is much the same as that of the official strophanthus hispidus.

THE SIDLAW SANATORIUM.—From time to time within the past few months notices have appeared in the Press relative to the proposed municipalisation of the Sidlaw Sanatorium for Consumption, an institution near Dundee containing 40 beds and maintained Ly public subscription. It now appears, however, as though the proposed scheme has fallen through just at the moment when it seemed about to culminate in success. In the scheme proposed by the Medical Officer of Health, and taken up with energy by the Public Health Committee, there was to be a threefold campaign against tuberculesis—compulsary potified campaign against tuberculosis—compulsory notifica-tion, sanatorium treatment of curable cases, and segregation of the incurable. It seems that in Dundee the public health rate falls entirely on occupiers, not on owners, of property, and to meet the cost of upkeep of the sanatorium a special sanatorium rate of 2d. per £ was proposel to be levied, falling equally on owner and occupier. Arrangements for the transfer of the sanatorium were almost complete when so strong an agitation was raised by those who considered their interests affected by the incidence of the sanatorium rate, that the Town Council rescinded its resolution and cancelled the agreement. If, as has been stated, this is due entirely to a dislike of the owners of property to bear their share of a new development of the public health rate, it is very regrettable from the point of view of the general community. It must not, how-ever, be forgotten that many of those who are most active in fighting against the ravages of tuberculosis still hold that the duty of the community is limited to prevention of the disease by notification, disinfection and segregation, and that the idea of its attempting to cure early cases opens up a very wide field of possible responsibility.

### BELFAST.

PHARMACY ACT PROSECUTIONS.—Three Belfast druggists were last week fined for compounding and retailing medical prescriptions, without being properly qualified. In one case an interesting point to medical men arose, and that was, what constituted a prescription? In the case in point the prescription was written on a paper with a printed heading, containing the doctor's name, and it was signed with his initials, but some doubt was expressed as to whether in the eyes of the law such a document is a medical prescription, if it is not signed with the full name.

BELFAST HEALTH JOURNAL.—It is nearly twenty years since Dr. Henry O'Neill published the first number of the Belfast Health Journal, a periodical designed to castigate evil-doers in sanitary matters, and teach the ignorant the way of health and happiness. Since then the journal has appeared with as much regularity as a volcanic eruption. The proprietor and editor has lately made school sanitation his special hobby, and in his latest issue he deals with the defects of the Irish schools in a very thorough manner. It is a fine subject for an ardent reformer, and Dr. O'Neill has always been a hard hitter. Now that he is qualified as a barrister as well as a medical man, his blows are no less vigorous, and better aimed than ever Photographs both of new and old schools make the matter plain to the man in the street and his wife in the kitchen, for whom the publication is specially designed, and there can be little doubt that its effect will be good. Country as well as city schools are dealt with.

GOLF.—A very handsome cup has been made to the order of the golfing members of the Ulster Medical Society by Messrs. Sharman Neill and Co., of Belfast,

on the model of the celebrated Ardagh Cup, perhaps the finest specimen of old Irish silver work extant, which is now in the Kildare Street Museum, Dublin. This cup is to be known as the "Belfast Cup," and is to be offered for competition to medical golfers during the Belfast meeting of the British Medical Association next July. It will be played for at Newcastle, Co. Down, on Friday, July 30th, by bogey score.

### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

### "EMPTY POCKETS."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—When I penned the letter which you honour me by printing to-day under the above heading, I did not imagine that in the Times of this date there would have been afforded some more illustrations of the literally shameful position before the law which our profession holds in comparison with dentistry, and with veterinary surgery. This position is entirely due with veterinary surgery. This position is entirely due to the apathy of our leaders, and of the organised bodies, like the British Medical Association and medical defence societies, which ostensibly exist to protect the honour, and promote the interests of our profession. It has been pointed out in your pages more than once by a well-known writer on this subject, that, from the sordid point of view, the practice of medicine and surgery by unqualified pretenders, including the vast amount that is carried on under the cloak of the traffic in worthless nostrums and bogus apparatus, does not constitute entirely an injury to the legitimate practitioner. The damage to the public health to which fraudulent practice of all kinds gives rise makes in the end much work for qualified men. But the fact that doctors have no protection by the State is extremely derogatory to them as a body; and there can be no doubt that the respect of the mass of the public for them would be greatly increased if the Government would practically demonstrate the fact that they are worthy of due recognition and consideration. Neither the public nor our statesmen are cognisant of the facts of the case—these will never be authoritatively set forth until the whole matter has been gone into before an unimpeachable tribunal, a Royal Commission, such as you have so ably and persistently advocated. The cases to which I allude above were heard in different London police courts on May 11th. In one case, at Lambeth, a man was fined £10 and two guineas costs; in a second case, at North London, a man was fined £20 and five guineas costs for the offence of using a description implying that he was qualified to practice dentistry. In neither case did it appear that a professional title had been employed. Such convictions are impossible under the Medical Acts. Not only may unqualified pretenders use words implying that they are qualified, but they can with impunity adopt bogus titles, and employ phraseology in their advertisements sufficient to lead even the educated public to accept them as distinguished members of the medical profession. This state of things is, of course, not the sole cause of the emptiness of the poor practitioners' pockets, but it forms a potent factor in the causation of this deplorable condition.

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.

May 12th.

GENERAL PRACTITIONERS AND MIDWIVES. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-I cannot allow Dr. Griffith's letters to pass without comment. He has strayed right away from the points which were originally under discussion. He says that we do not call the St. John's Ambulance trained "quacks." I quite agree with this remark; but let us not forget that the Ambulance man gives his services in the event of an emergency, and then the patient is taken care of by a duly qualified medical man. The temporary nature of the treatment and the

necessity of calling in a medical man as soon as possible are impressed upon all Ambulance candidates. Let us hope, for the sake of our profession and also for the sake of the natives that the day is and also for the sake of the harves that the day is not very far distant when we shall be able to abolish the Zenana Medical Mission College with its shortened curriculum, and we shall be able to send to the natives as skilled and well qualified practitioners as we have at home. I do not wish to disparage the good work of this medical college, but the sooner we can replace it by sending out to the mission field duly qualified medical men and women the better it will be for all concerned.

I am, Sir, yours truly, S. J. Ross.

Monkhams, Bedford. May 12th, 1909.

THE LATE SIR WM. T. GAIRDNER, M.D., F.R.S. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir,-In response to the wishes of Lady Gairdner and her family, I have undertaken to edit the medical and scientific papers and articles of the late Sir William Tennant Gairdner, and to preface the collection with a biography.

In order to render the work as worthy as possible of the memory of the late professor, I am desirous of enlisting the sympathy and help of his friends. I venture, therefore, to request through your columns that anyone who has in his possession any letters or other literary remains of Sir William Gairdner will be so kind as to communicate with me.

I am, Sir, yours truly, G. A. Gibson, M.D.

3, Drumsheugh Gardens, Edinburgh. May 12th, 1909.

AN URGENT APPEAL FOR ASSISTANCE. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,-We desire to bring under the notice of your readers the case of a registered medical practitioner of many years standing, and in good repute in Dublin. Owing to circumstances of a family nature, not in the least degree reflecting on his character or on that of any member of his family, and to his indifferent state of health of late, he is in urgent want of pecuniary help to enable him to maintain his position. We therefore venture to appeal for that assistance to the members of his own profession, who are always

willing to help their brother practitioners.

Any of the under-signed will be glad to receive any donations that may be kindly sent in response to this

urgent appeal.

We are, Sir, yours truly,

Andrew J. Horne,
Pres. Royal College of Physicians of Ireland. JOHN LENTAIGNE,

President Royal College of Surgeons,
JOHN W. MOORE, M.A., M.D., D.Sc., F.R.C.P.I.,
40 Fitzwilliam Square, Dublin.
CHARLES A. CAMERON, Kt.,
51 Pembroke Road, Dublin.

May 11th, 1909.

THE ADMINISTRATION OF ANÆSTHETICS. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter of Dr. Kirkpatrick on the above subject in your last issue contains an argument which has now been trotted out many times in the past few months without its unsoundness being discovered. He says: "The number of deaths recorded as occurring during the administration of anæsthetics by qualified dentists compares, in every wav. most favourably with the number recorded as occurring during the adminis-tration by medical men." It would be strange indeed if the administration of an anæsthetic for the extraction of a tooth were accompanied by as grave a risk as that for, let us say, a laparotomy. Yet this is the comparison relied on by Dr. Kirkpatrick and many others who have written about the position of dentists in regard to the administration of anæsthetics. If anything is to be proved as the relative capacities of

medical men and dentists to administer anæsthetics, then the comparison must be between operations of a similar character in each case. It can hardly be maintained that of the fatalities which occur in dental work more in proportion have occurred in the hands of medical men than in the hands of dentists. in the hands of domining I am, Sir, yours truly,

MEDICUS.

### **OBITUARY.**

ERNEST ALFRED SNAPE, M.D. BRUSSELS. We regret to announce the premature death of Dr. Ernest Alfred Snape, at his residence in Welbeck Street, London. The cause of death was heart failure Street, London. The cause of death was heart failure following an operation for appendicitis by Sir Watson Cheyne. The eldest son of the late Rev. A. Snape, Vicar of Bury St. Edmunds, he was educated at Charing Cross Hospital, University College, London, and the University of Brussels, where he took the M.D. degree in 1893. Dr. Snape was author, with Dr. W. K. Sibley, of a report on Special Hospitals in London with reference to the custom of the street. with reference to the question of hospital abuse. His genial nature made him the centre of a large circle of professional and social friends, to whom his sudden death will be a source of deep and heartfelt regret. At the time of his death he had built up a large and lucrative private practice. Amongst other posts he held that of Honorary Physician to the Cripples' Home, St. Marylebone, and the Governesses' Benevolent Institution.

DR. WHITTLE, OF BRIGHTON.

THE death of this gentleman, which occurred last week, at Las Palmas, Canary Islands, was not unexpected; his health had been failing for some time, pected; his health had been failing for some time, and the visit to the Sunny South was undertaken in consequence. Dr. Whittle, who for the past 33 years had resided at Brighton and was a prominent practitioner of the town, had retired from active practice for some time past. He obtained the Membership of the Royal College of Surgeons, England, in 1873, and the Fellowship in 1876. He was also a graduate of London University, taking the M.D. Degree in 1882. He was elected President of the Brighton Medico-Chirurgical Society in 1801, and was also a hon-Chirurgical Society in 1891, and was also a hon, physician at the Brighton and Hove Dispensary and formerly house surgeon to the Brighton Hospital for Women and Children.

### SPECIAL ARTICLES.

### INTERNATIONAL MEDICAL TEMPERANCE APPEAL.

IT is proposed to present at the Twelfth International Congress on Alcoholism, to be held in July, 1909, in London, an International Medical Temperance Appeal to the rulers, teachers, and clergy of all nations.

Many of the Continental countries are already well represented by signatories. It is hoped that Great Britain and Ireland may not be behindhand in the matter. It is asked, therefore, that all who are willing to sign will intimate the fact immediately to Mr. W. McAdam Eccles, M.S., 124 Harley Street, London, W.

APPEAL TO THE MEDICAL PROFESSION OF ALL NATIONALITIES.

The International Union of Medical Abstainers, founded at the Eleventh International Congress against Alcoholism, held at Stockholm in 1907, invites medical men of all nationalities to unite for common action to break the bonds of alcoholism. This appeal is based upon the following main considerations:—

(1) Many of the physical ills we have to bear are, and will be, the result of the action of alcohol taken in

the form of a beverage.

(2) To the medical profession falls the special duty

of instructing people on these matters.

(3) The consequences of the continued use of alcohol, as shown by the history of the human race, are always the same; demoralisation, degeneration of individuals, and decadence of nations

(4) Spirituous drinks of any kind are unnecessary for the healthy individual; a desire for them exists only where it has been created artificially.

(5) All normal organisms perform their various functions better without alcohol, which is specially

dangerous to young or growing tissues.

(6) For the welfare and preservation of future generations it is necessary to discontinue the use of alcoholic beverages, as only by widespread abstinence can alcoholism with its consequences be met and restricted.

On these grounds we members of the International Union of Medical Abstainers call upon our Medical brethren of all lands to unite with us in the struggle against alcoholism and to sign the following appeal:

APPEAL FROM THE PHYSICIANS OF ALL COUNTRIES
To all Rulers, Governments, Representative
Assemblies, to all tutors, teachers, clergymen, and to all who have at heart the welfare of our race and of

We members of the medical profession, believing that by our studies and opportunities of recognising and estimating the nature and action of alcoholic beverages, we are qualified to offer an opinion, affirm it as our strong conviction that these beverages are not only unnecessary, but are extremely injurious, and that the evils which arise and are ever breaking out from the consumption of alcoholic beverages can, and must be, eradicated and prevented. We believe that young people especially should receive careful and as full instruction as possible, and should be trained by example, as well as protected by law, to abstain from the consumption of alcoholic beverages.

We are fully convinced that some such step must be taken in order to create a sober world and to promote and insure the happiness, welfare, and progress of the

human race.

(Signed) Ridge (Enfield) (lately deceased).
Dr. Olrik (Frederiksvaerk).
Dr. Laitenen (Helsingfors).
Dr. Holitscher (Pirkenham-Dr. Holitscher (Pirkenhammer).
Dr. Vogt (Kristiania).
Dr. Santesson (Stockholm).
Dr. Stein (Budapest).
H. N. Barnett, F.R.C.S. (Helfart).
T. H. Bickerton, M.R.C.S. (Liverpool).
R. H. Blakkie, M.D. (Edinburgh).
W. Calwell, M.D. (N. Wales).
J. G. Clegg, M.D. (Manchester).
E. MacDowell Cosgrave, M.D. (Dublin).
J. Dixon, M.B. (London).
W. McAdam Eccles, M.S., F.R.C.S. (London).
Surg-Gen. G. H. Evatt, M.D. (London).
A. P. Fiddian. M.R.C.S. (Cardiff).
R. H. Fox, M.D. (London).
A. F. Gould, M.S., F.R.C.S. (London).
J. S. Greer, L.R.C.P. (Dublin).
T. W. Hay, M.B. (Newcastle-on-Tyne).
W. F. Hazel, M.R.C.S. (London). on-Tyne).
W. F. Hazel, M.R.C.S. (Londou)

E. C. Hearne, L.B.C.P. (Lon-G. B. McKenurson,
(Glasgow.
G. McKendrick, M.D. J. G. McKendrick, M.D.
(Stonehaven).
R. Paramore, M.D. (London).
H. J. Paterson, M.B.
F.R.C.S. (London).
Surg. Major G. K. Poole.
M.D. (London).
A. B. Prowse, M.D. (Bristol).
V. H. Rutherford, M.D. (London). don). Rushbrooke, M.R.C.S. T. Rusnorouse,
(London),
J. G. Sharp, M.D. (Leeds),
Sir A. R. Simpson, M.D.
(Edinburgh),
E. Cloude Taylor, M.D. (London) E. Cloude Anyon.
don).
W. B. C. Treasure, M.D.
(Carlif).
Heywood Smith, M.D. (London).
Wallace Smith, M.B. D (London). Sims Woodhead, M.D. (Cambridge). Muckie Whyte, M.D. (Dun-J. Mackie whyte, m.D. (Dun-dee). H. Wi'liams, M.D. (Northampton).

### ADULTERATION OF DISINFECTANTS.

In the House of Commons, recently, the President of the Local Government Board was asked by Mr. J. D. Rees whether, in view of the promise made behim in 1907, and the statement of Professor Hewlett in the recent Milroy lectures at the Royal College of Physicians, that, in 1905, 1906, and 1907, 28,000 gals., 37,000 gals., and 66,000 gals. of liquid were sold as disinfectants under the Privy Council Order of 1900, whereby grocers and oil and colourmen are prohibited from selling disinfectants containing more than 3 per cent. of carbolic acid (the result of which was to place a premium on adulteration and inefficiency), he would state what steps he proposed taking to remedy the evil.

Mr. C. F. Masterman, who replied, said that at

present he is not empowered to fix standards of disinfectants, and it did not appear that he could usefully take action in the matter. He added that there is little public advantage in the domestic use of disinfectants as deodorants. Where they are used to remove infection they are commonly employed under the advice of a Medical Officer of Health or other medical man, who might be trusted to order disinfectants which are

Mr. Rees asked the hon, gentleman whether he was not aware of the fact that in other Government departments a standard was enforced by administrative custom. Such an extension of the standard would be an advantage to the public health.

No answer was returned.

The promise made by the President of the Local Government Board, to which Mr. Rees referred, was to the effect that if it could be shown that people of the poorer classes were in the habit of using deodorants as disinfectants, and not merely as deodorants, he would consider what steps could be taken to ensure that preparations sold as disinfectants should possess some actual disinfective action. The figures quoted by Mr. Rees, which represent the sale of "disinfectants" in small quantities to poor people, are ample evidence that there is a large demand for disinfectants. Mr. Masterman, it will be noted, is of the opinion that there is little advantage in the domestic use of disinfectants as deodorants, but no one, I imagine, would deny that if deodorants as such be used at all, it would be very much to the public advantage that they should possess disinfective efficiency.

In all Government departments, with the solitary exception of the Board of Agriculture, a guarantee is required that the disinfectants used by the department shall have a certain stated efficiency. If this precaution be necessary in the circumstances in which disinfectants bought by a Government department would commonly be used, how much more necessary must it be when they are to be used in the homes of

the poor.

Mr. Masterman's contention that where disinfectants are used domestically for the removal of infection they are commonly employed under the advice of a Medical Officer of Health or other medical man, "who might be trusted to order disinfectants which are efficient," is unsound. Apart from the curious fact that obsolete disinfectants and methods of disinfection are still not uncommonly advccated by otherwise highly qualified medical men—as witness the prescription by an eminent Irish official of sulphurous fumigation in tuberculosis the practitioner would, in the ordinary course, probably recommend or order the use of "a disinfectant" without specifying what the disinfectant should be. The result, at any rate, in the humbler class of houses, would be that one of the useless preparations sold by grocers and oil and colourmen would be used.

The remedy is very simple. Under the Privy Council Order of 1900, the grocer and oil and colourman is prohibited from selling disinfectants containing more than 3 per cent. of carbolic acid, and, as a consequence, the preparations sold as disinfectants cannot possibly possess any disinfective efficiency. The rescindment of this Order, and the substitution of one requiring that all disinfectants sold as such shall possess a guaranteed minimum carbolic acid co-efficient, would not only remove the evil which now exists, but would ensure that preparations sold as disinfectants would be capable of efficient disinfection. This surely would be greatly

to the public advantage.

### MILITARY & NAVAL MEDICAL NOTES.

A VERY stupid and useless system of competitive hospital diets, says the Military Mail, of April 30th last, has sprung up in Aldershot of publishing in "command orders" the cost per head for the subsistence of the patients in the various military hospitals in the command. It is obvious, says our military contemporary, that the comparison is being made to force the hands of the medical officers in charge to keep the cost

per head down to the lowest limit, a system which may have grave results on the health of the patients should those in authority insist on making unfavourable comparisons, and so compel those in charge to economise at the expense of the patients' food. In this monthly so published the Cambridge Hospital is shown as having spent £1 1s. 5d. per head per month for the sustenance of its patients, whilst the Bordon Hospital spent only 12s. 8d., and the Longmore Hospital spent only 12s. pital, only three miles away, spent £,2 7s. 8d. The difference in the amounts can no doubt be traced to the peculiar conditions under which each hospital exists, and the difference in the class of patients, and is capable of perfectly fair explanation. So no good can accrue from publishing these comparisons without also giving the special reasons, known to the officials, why the cost varies so greatly with the different hospitals. It is well-known, we should add, that the Cambridge Hospital at Aldershot generally treats the severest cases. The arrangement is somewhat unsound.

THE Naval and Military Record, of April 29th, has a letter headed "Sisters in R.N. Hospitals," which gives support to the quotations we gave in our issue of May 5th on the same subject. It looks as if something is defective in the Regulations for Sisters in Royal Naval Hospitals.

Another Naval medical subject attracting attention is the poor rate of pay and slackness of promotion in the sick berth staff of Naval hospitals which a Naval surgeon has written up lately.

INVALIDS disembarked in London from stations abroad are in future to be sent direct to the Royal Naval Hospital, Chatham, instead of to the ports to which they belong, as has hitherto been done. The Royal Naval Hospital at Chatham is a large and important charge, and has for years past been administered by a Deputy Inspector-General of Hospitals, R.N., and also an Inspector-General.

HIS EXCELLENCY THE COMMANDER-IN-CHIEF IN INDIA, as President of the Central Executive Committee of the St. John's Ambulance Association, has been pleased to appoint Major R. J. Blackham, R.A.M.C., to be Honorary Secretary of the Indian branch, in succession to Major A. M. Cameron, who is shortly proceeding to England.

THE work of disinfecting the barracks occupied by the troops of the British Army of occupation in the Citadel at Cairo, Egypt, has now been finished. The work has been in hand over a month, during which soo rooms were done, and, as might be expected, thousands of bugs, cockroaches, fleas and other pests were exterminated. In addition to these, in one store alone 61 rats were found, suffocated by the gas used for disinfection. The military authorities are to be commended for adopting this very successful system of disinfection.

A TREASURY White Paper shows that recruiting for the Army Service Corps, Royal Army Medical Corps, and Special Reserve, with drill on enlistment, has brought about an excess of expenditure of £30,000.

THE unusual sight of a parade of mounted nurses of the First Aid Yeomanry Corps in Regent's Park riding school caused great interest and excitement. First Aid Nursing Yeomanry Corps is not yet officially recognised.

### REVIEWS OF BOOKS.

OPERATIONS ON THE UTERUS AND PERINÆUM. (a)

This work deals with a limited portion of gynæcology, but in a manner which renders it most

(a) "Operations upon the Uterus, Perinsum, and Round Ligamenta."
By W. T. Stewart M'Kay, M.B., M.Ch., B.Sc., Senior Surgeon
Lewisham Hospital for Woman and Children, Sydney. Pp. 470 with
148 photographs. London: Ballilere, Tindall and Cox. 1909. Price 21s.

useful and explaint. The author has undertaken the difficult task of explaining the method of repairing the perinæum, and has adopted illustrations as the chief method of explaining the operations, with a short description in the letter-press. He describes the operations which he has found most useful in his own practice, and carefully points out the limitations of each, and indicates the class of cases in which the different operations may be expected to effect cures. The work commences with the consideration of the muscular and fascial constituents of the pelvic floor, and a description of the action of the different muscles in their normal state and of what occurs when rupture takes place, showing how distension of the perinæum is caused by the retraction of the muscles or the loss of the proper points of attachment from which they should act so as to resist the intra-abdominal pressure. The importance of both muscle and fascia in the formation of the pelvic diaphragm is impressed, and it is shown that the levatores ani are the principal structure of the diaphragm, but requiring for the maintenance of its integrity the support of the fasciæ. Tears of the perinæum are divided into three classes, and the author points out that the class consisting of "deep injuries without any superficial rent" is the one most often neglected and giving rise afterwards to displacements. In dealing with displacement of the uterus the many

In dealing with displacement of the uterus the many operative methods are considered, and the indication for each explained. The Alexander Adams operation is extensively illustrated, and the technique fully described, and many of the difficulties found in performing the operation explained, and the way to avoid them shown. Ventro-suspension after Howard Relf, or division of the round ligaments and suturing the ends into the abdominal wall, are the operations recommended when there is necessity for opening the abdomen. Ventro-fixation is advised only when the child-bearing period is passed, or after sterilisation. In closing the abdomen the author recommends No. 2 plain catgut for closing the fascia, and has found it satisfactory, but it appears rather insecure owing to the risk of too easy absorption. Curettage of the uterus and the indications for this operation are extensively dealt with at the end of the work. Some of the uses for the curette are open to criticism, and will not be universally agreed with, such as curettage for amenorrhæa due to mental disturbance, and in suspected cases of ectopic gestation before rupture for diagnostic purposes. Webster is quoted in support of this, but he points out that, although the finding of decidua is positive, the not finding is not negative. Also curettage should not be laid down as always necessary before plastic operations on the perinæum or uterus, for although the greater number of these patients have uterine disease as well as the other condition, there are a large number in which the endometrium is perfectly healthy, and therefore should be left untouched.

In spite of the inevitable points on which difference of opinion will be held, Dr. McKay has produced a book which will meet with general agreement in its essential parts, and which contains very few, and those very minor points for dispute. The illustrations are numerous and beautifully reproduced, and bring out the separate steps in the operations in a manner which makes them easy to follow and understand. The letterpress is large and clear, and the whole volume, which is crown 4to, with xxvii. and 454 pages, and 148 plates, is handsomely produced and well worth possessing by anyone who wishes to learn or who attempts to carry out the plastic operations on the perinæum and uterus.

### MEDICAL NEWS IN BRIEF.

#### Reyal College of Surgeons in Ireland,—General Meeting and Election of Officers.

A MEETING of the College will be held on Saturday, June 5th, at one o'clock, to receive the annual report of the Council.

A meeting will also be held on Monday, June 7th, at one o'clock, pursuant to the provisions of the

Charters, to elect a President, Vice-President, Council, and Secretary of the College for the ensuing year.

Fellows who may desire to have their names printed

Fellows who may desire to have their names printed on the list of candidates for office, will please signify their wish by letter, to the Registrar, at the College, on or before Tuesday, May 25th, as it is necessary to include the names in the voting papers which are forwarded to the Fellows; and no candidate is eligible unless his application is received within the date specified.

### St. Bartholomew's Hospital.

THE LORD MAYOR had a conference at the Mansion House on May 14th with the Masters and Clerks of the leading City Guilds with reference to the financial position of St. Bartholomew's Hospital. He read to them the following letter:—

Marlborough House,, Pall Mall, S.W., April 6th, 1909.

My dear Lord Mayor,

I am directed by the Prince of Wales to inform you that, as President of St. Bartholomew's Hospital, he has lately had an opportunity of learning from Lord Sandhurst, the treasurer, that there is now an annual deficit of about £12,000 in the working of the hospital, due in a large measure to payment of interest on a capital debt of approximately £170,000. His Royal Highness desires me to say that he has received this information with much regret, as he would view with grave concern the necessity for in any degree curtailing the work of what is the only general hospital within the City boundaries. His Royal Highness sincerely trusts that funds may be raised to prevent the possibility of such an unfortunate contingency.

Yours very truly,
ARTHUR BIGGE.

The Lord Mayor further stated that on a recent occasion the Prince of Wales had alluded, in conversation with him, to the same subject and emphasised his view that, as St. Bartholomew's was the only general hospital in the City of London, it behoved the citizens to see that its efficiency was fully maintained. Lord Sandhurst, the treasurer of St. Bartholomew's

Lord Sandhurst, the treasurer of St. Bartholomew's Hospital, who was present, gave details as to its financial position, explaining that some £170,000 was owing in respect of a loan contracted in 1902 in connection with the purchase of a portion of the site of Christ's Hospital and of other expenses in the development of the institution. There was now an excess of expenditure over income of about £12,000 a year. As showing the need of a hospital in the City, he mentioned that 620 beds were now occupied and that last week 385 cases of accidents were treated in the hospital. They at present got no help from King Edward's Hospital Fund, but they intended to apply at the next distribution.

The Master of the Mercers' Company handed in a donation of £500 towards the fund from his Guild.

### listrict Nursing Congress.

THE Jubilee Congress of District Nursing in Liverpool was held last week. Mr. Archibald Williamson, M.P., the Chairman of the Congress, who had been the host during their stay in Liverpool of Princess Louise and the Duke of Argyll, said Princess Louise had received a letter from the King in which his Majesty highly approved of her Royal Highness having come to the Congress, and he hoped it would result in very much good to the cause of district nursing.

wery much good to the cause of district nursing.

Sir Thomas Hughes presided at the first of two
sessions held in the morning, at which school nursing
in connection with district work was discussed.

Mr. H. R. Rathbone read a paper on "The Work of School Nursing in Liverpool." This, he said, was at first tried experimentally by the late Mr. William Rathbone in 1895, and about six or seven years ago it was taken over and extended by the committee of the District Nursing Association.

Sir Dyce Duckworth presided over another section, and Lady Helen Munro Ferguson introduced the subject of discussion—"The District Nurse." Directing attention to the standard required in the district nurse.

she said that at present no one was agreed either as to what constituted a trained nurse or what constituted a training. A definite standard for a fully trained nurse ought to be laid down by a nursing council, and then they would be able to make up their minds as to the

best kind of nurse to employ for district work.

At the concluding session several addresses were given on "Future Developments of District Nursing."

Miss E. F. Rathbone gave an account of an experiment which is being tried by the Liverpool Women's Industrial Union in establishing a new class of recruits as sick-room helpers. The Bishop of Liverpool presided and gave an address.

### Royal Sanitary Institute Dinner.

THE DUKE OF NORTHUMBERLAND, President of the Royal Sanitary Institute, was supported by a large assembly at the annual dinner of the Institute at the assembly at the annual dinner of the institute at the Langham Hotel, on May 11th, the company including Mr. Searles Wood (Chairman of the Council), Sir Francis Sharp Powell, M.P., Sir Dyce Duckworth, the Right Hon. Dr. R. Farquharson, Director-General Porter, R.N., Surgeon-General Sir Alfred Keogh, Sir Picture, Sir W. Emerger Sir Alfred Ready, and A. Binnie, Sir W. Emerson, Sir Henry Burdett, and

Sir J. Tweedy.
Sir A. Keogh, replying for the Services, pointed out that under the voluntary system of the Territorial Force the patriotism of the medical profession had given all that was wanted. It had been possible to give special work to men exclusively engaged in sanitation, a con-dition which was not fulfilled in any other army in Europe, and the service was now being completed throughout the whole force. He hoped by their efforts greatly to reduce the hospitals and humanitarian work, so that it would only be necessary to make provision for the wounded, and not for sufferers from disease which would be prevented.

The Duke of Northumberland, proposing the toast of the Institute, said that the advance of sanitation depended a good deal on the course adopted by the Government towards local authorities. On them had been laid new duties, but the people who did not recognise the necessities of the case resented the accompanying rise of rates. Much tact, therefore, was required in advocating reforms, and sanitarians should back local authorities in claiming assistance from the Exchequer to fulfil the new burdens laid on them by the Legislature.

### A Midwife's Character and an Alleged Palse Certificate.

AT the Eccles Police Court, on the 10th inst., charges were made by the Public Prosecutor under the Midwives Act against Mary Ann Marsh, Patricroft, who was accused of having procured admission to the midwives' roll by producing a false and fraudulent certificate of good character, and Dr. Sidley, who was accused of having aided and abetted the woman by signing the certificate. Mr. Ogden, acting for the

Medical Defence Union, appeared for the defendants. Inspector Howarth said that Mrs. Marsh, who applied in March, 1905, to be placed on the roll of midwives, had more than a dozen convictions against her for drunken and disorderly conduct, including two commitments since July, 1000, the last being in February of this year. When the present summons was served on Mrs. Marsh she was under the influence of drink, and she said she was sorry for Dr. Sidley, who had signed her certificate.

Evidence was given that Dr. Sidley had signed the certificate believing that Mrs. Marsh was a steady and very deserving woman, when he had no information to Evidence was not called to prove Dr the contrary.

Sidley's handwriting.

Mr. Ogden contended that Mrs. Marsh was sober, trustworthy, and of good moral character so far as her business life went, and that what she had done in her private life had no connection with her work as a midwife. With regard to Dr. Sidley, there was no evidence of wilfulness or fraud on his part. Whatever he had seen of Mrs. Marsh she had always been capable for her business.

The charge against Dr. Sidley was dismissed; Mrs. Marsh was sent for trial to quarter sessions.

#### The Hospital for Sick Chidren.

THE DUKE OF FIFE presided at the 57th Annual Court of Governors of the Hospital for Sick Children, Great Ormond Street, London, on Thursday last. The annual report referred to the opening of the new outpatient department, the cost of which was defrayed by Mr. W. W. Astor. The accounts showed an excess of income over expenditure of £714 16s. 2d., but on the other side there was a debt to the bankers of £4,500. With one exception, the income from every important source had increased during the past year. The mortage debt stood at five and the past year. gage debt stood at £15,349. The report was adopted on the motion of the Duke of Fife, seconded by Mr. Lucas. Lord Aberdare, moving the re-election of the President and Vice-Presidents, said he did not know how many institutions of the kind the Duke of Fife was connected with, but he was always faithful to that hospital. Mr. Arthur Lucas moved that sanction should be given to expenditure not exceeding £3,000 for the reconstruction of the old out-patients' department and explained that accommodation was to be provided for bacteriological research, an X-ray department, a dining-room, and other things. They were not launching out into any extravagance, he said, but the modern equipment of hospitals had become so complicated and extensive that they must carry it out thoroughly. The motion was agreed to, and sanction was also given to an expenditure of £563 on the reconstruction of a house for the accommodation of nurses who are sent out on private cases.

#### Royal College of Surgeons, England.

Royal College of Surgeons, England.

The following candidates, having passed the required examinations and conformed to the by-laws, were admitted members of the College on May 13th:—

A. Abrahams, B.A.Cantab.; H. W. L. Allott; Mukhtar Ahmed Ansari; R. R. Armstrong, B.A. Cantab.; J. L. Atkinson; K. J. Aveling; B. F. Bartlett; M. Bates, B.A., M.B.Oxon; Phirozshah Byramji Bharucha; H. E. Bloxsome; T. L. Bomford; W. F. Bowen; H. Bowrung, B.A.Cantab.; E. C. Braithwaite; T. F. Brown; W. H. Butler; F. G. Caley, B.A.Cantab.; F. G. Cawston, B.A.Cantab.; H. D. Clapham, A. J. Clark, B.A.Cantab.; J. P. Clarke; K. Comyn, B.A.Cantab.; R. B. Dawson; Canut Deuntzer; J. R. Dick, B.A.Cantab.; T. B. Dixon; J. R. B. Dobson; M. Donaldson, B.A.Cantab.; A. W. Duńcan; G. H. Dunn, M.A.Cantab.; L. W. Evans; T. Evans; P. C. Field; H. W. Gabe; E. B. Garrard; P. K. Gilroy, B.A.Cantab.; C. Gouldesbrough, M.A. Oxon.; H. S. Hall, B.A.Cantab.; D.J. Harries; T. Harrison; H. Hudson; E. P. L. Hughes; R. H. Hutchinson, B.A.Cantab.; V. P. Hutchinson; R. S. Ingersoll; R. P. Jones; C. F. V. Kebbell; Latafat Husain Khan; H. G. Kilner; S. J. Lee; R. H. Mawhood, B.A.Cantab.; J. K. Milligan; H. E. Hall Mitchell; E. B. Morley; H. R. Moxon; Naranji Ranchhodji Naik; F. C. Nichols, L.D.S.Eng.; R. D. O'Leary; D. G. S. R. Oxley; G. F. Page; R. Pearse; L. B. Perry, B.A.Cantab.; A. Rhodes; A. D. Rope; F. A. Roper, B.A.Cantab.; A. Rhodes; A. D. Rope; F. A. Roper, B.A.Cantab.; A. Shenstone; S. Shepheard; H. G. Smith; R. R. Smith; E. R. Stone, B.A.Cantab.; T. W. R. Strode; W. F. Sucliffe; H. L. Tasker; H. A. Treadgold, B.A.Cantab.; R. J. Vernon, B.A.Cantab.; D. Wainwright; H. C. Waldo; G. R. Ward; L. M. Webber; M. W. E. Wright, M.A.Oxon.

Conjoint Examinations in Ireland.

The following candidates have passed the final projection.

### Conjoint Examinations in Ireland.

Conjoint Examinations in Ireland.

The following candidates have passed the final professional examination of the Royal College of Physicians and the Royal College of Surgeons, May, 1909:—B. G. S. Boles, F. H. Gleeson, H. G. Massey-Miles, R. Power, E. Smith, G. C. Sneyd, C. H. Stringer, B. Wallace, J. McG. Williams.

Diploma in Public Health:—Capt. W. W. Browne, M.R.C.S., L.R.C.P., R.A.M.C. (with honours), R. F. O. Dickinson, L.R.C.P. and S.I., R.A.M.C., B. D. Gibson, L.R.C.P. and S.I., D. J. O'Connor, M.D. R.U.I., F.R.C.P.I., Capt. N. D. Walker, M.B. Univ. Edin., R.A.M.C.

### Summary of Recent Medical Literature, English and Foreign.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

The Treatment of a Case of Extensive Infantile Paralysis by Operation and Apparatus.—Rowlands (Brit. Med. Journ., April 10th, 1909) describes the case of a girl, æt. 17, whose hips and knees on both sides were fiexed and the lumbar spine arched, the result of infantile paralysis when three years old. Standing and walking were impossible, but the patient could shuffle along by grasping and moving her feet with her hands. along by grasping and moving her feet with the maintained. The paralysis appeared to be complete below the waist except for the power of—(1) very weak extension and abduction of the right hip; (2) weak flexion and adduction, and very weak abduction and extension of the left hip; (3) slight power in the right peroneus tertius and the flexors of the toes, and of the left calf muscles. Both ankles were flail. The reflexes were abolished in both legs, but sensation was unimpaired. The following operations were carried out at one sitted. ting: While the left index finger was kept constantly over the anterior crural nerve, a curved long tenotome was introduced about 1 in. below and outside the anterior superior spine between the skin and the auterior contracted structures, which were gradually divided, while an assistant pressed the knee backwards. Through the same puncture wound the shortened fasciæ on the outer side and the abductors were divided. spite of vigorous manipulations, it was not possible to straighten the hip till the anterior tissues were divided down to the neck of the femur. The shortened tendons behind the right knee were next divided subcutaneously, the left knee not requiring this. The kneejoints were opened through curved incisions across the patella ligaments, which were divided, and the upper end of the tibia and the lower end of the femur, just short of the epiphyseal line, were sawn off in each limb. Thus each limb had to be shortened about an inch and a-half before it could be straightened without exerting too much tension upon the contracted popliteal vessels and nerves. The knee-cap and a good deal of pendulous skin was removed on both sides. The patient was at once fixed in a double Bryant's splint without extension. Five weeks after operation an apparatus was applied, and the patient was instructed and helped to learn the arts of balancing, standing, and walking. The apparatus was provided with toelifting springs and T. valgus straps. There were no
joints at the knees, which were kept firmly fixed by The side-irons were made to take some of the weight off the legs, and the whole apparatus, including the pelvic girdle, added to the stability of the body. When the patient left hospital nine weeks after operation she could walk on the level with the aid of a little support from crutches, and could stand alone without these.

Transfusion of Blood for Pernicious Anæmia.—Lucy (Med. Rec., March 6th, 1909) reports a case of a woman, æt. 33. who, 18 months after he had operated on her for kidney abscess, developed pernicious anæmia during pregnancy. A living eight months' child was born on August 5th, 1908, with no loss of blood or sepsis. The anæmia and distress grew rapidly worse. The blood count showed 1,800,000 red blood corpuscles; hæmoglobin, 35 per cent.; megaloblasts present. Repeated blood examinations showed a condition of pernicious anæmia. On August 13th the author connected the husband's right radial artery with the patient's median basilic vein, and the blood was allowed to flow for 70 minutes. On August 14th her condition was better, and on the 15th she developed an appetite and ate a good breakfast. Colour returned to the nails and underneath the tongue, and from this time on improvement was very rapid, and she was discharged in good health on September 15th. A blood count on October 4th showed red blood cells 3,200,000,

with hæmoglobin 85 per cent.; no megaloblasts. According to later reports the patient's health is perfect. S.

Fistula Between the Stomach and Bile Passages, and Other Internal Biliary Fistulæ.—Mayo Robson (Brit. Med. Journ., 1st May, 1909) points out that though this condition may result from the breaking down of malignant growth, from ulceration of the stomach, duodenum, or colon, yet the most frequent cause of internal biliary fistula is gall-stones. The fistula may be either direct, or indirect through an abscess cavity. Usually the ulceration leading to fistula proceeds quietly and painlessly, producing very few symptoms, until, it may be, a gall-stone sets up absorption in its passage down the intestinal canal; or, after the formation of a fistula, all the symptoms pass away, and the patient makes a complete recovery. The author reports a case in which symptoms occurred due to gall-stones passing into the cystic and common ducts, the fistula having contracted. Sometimes pain beneath the right costal margin, more or less continuous fever of an irregular type possibly associated with rigors, are symptoms which accompany the formation of fistula. On examination there will be found rigidity of the right rectus, distension of the upper abdomen, and possibly a tumour. There may also be hæmorrhage, vomiting of gall-stones, and symptoms of intestinal obstruction. Intestinal obstruction may be acute, caused by local peritonitis leading to paralysis of the bowel; by volvulus of the small intestine; or there may be mechanical obstruction due to the passage of a large concretion through the small intestine. The writer cites a case in which a minute fistula into the colon was overlooked when separating very dense visceral adhesions, the result being the escape of visceral contents and peritonitis. Cases are also mentioned which leads the author to consider that silk ligatures at any operation on the biliary passages is fraught with risk of subsequent trouble.

Direct Blood Transfusion .- Berg (Med. Record, March 27th, 1909) records several cases in which this operation was performed with satisfactory results. He advises that no blood transfusion should be attempted except in cases of urgent necessity without previously determining whether the donor's blood will hæmolyse the blood of the recipient. With improved technique the modern operation is unattended with risk to the donor or the recipient. The basic principle of the anastomosis is to bring the intima of the artery everywhere into contact with the intima of the vein. The vessels to be anastomosed are first exposed and freed from their surroundings for about an inch, and clamped proximally and distally. The artery and vein are then divided, or an incision is made into the side of the vein if a lateral anastomosis is to be effected. After passing two guide sutures to hold the vessels lightly in contact, a fine, twisted, silk, continuous, through-and-through suture is used to complete the anastomosis. The method of anastomosis described by Crile, in which cannulæ are used, is an excellent and speedy procedure. There is as yet no means of measuring the amount of blood that is transfused. It has been the custom to depend upon the increase of hæmoglobin percentage of the recipient as a rough indication of the amount of blood transfused. percentage is taken before and every ten minutes during the operation. From a normal adult man sufficient blood can usually be transfused to raise the hæmoglobin of an adult donee to 65 or 70 per cent. The donor's blood during the transfusion does not show a proportional decrease Besides its use in severe acute hæmorrhage, the writer has found blood

transfusion to be one of the best means of preparing feeble and exsanguinated patients for major opera-tions. The author reports several cases which he has successfully treated.

Anæsthesia.-Humphry (Practitioner, Chloroform May, 1909) discusses the advantages of using chloroform as an anæsthetic in those instances in which the patient's general condition is manifestly very bad, and in which it is imperative that a general anæsthetic should be administered, and some inevitable operation performed. Such cases are not unusual when the patient is the subject of cancerous disease or suffering from septic infection. In such patients the heart is often failing, and this has been looked on as a special indication for the administration of ether rather than chloroform. Humphry is of opinion that if ether is given in such a case the tired heart is injuriously stimulated, and is scarcely able to respond, and, by raising the blood pressure, the amount of work it has to perform is increased. If, on the other hand, chloroform be given, the feeble heart is not stimulated, but the amount of work it has to perform is diminished by lowering the general blood pressure. In support of these views, Humphry quotes the Lancet and Hyderabad Commission's report on chloroform as follows:—"Chloroform has no power of increasing the tendency either to shock or syncope during opera-tions," and "if either shock or syncope from any cause does occur, it prevents, rather than aggravates, the dangers of chloroform inhalation; that in fatty degeneration of the heart chloroform in no way endangers it, but, on the other hand, is a positive advantage, by virtue of lowering the blood pressure and lessening the work it has to perform.'

The Pre-Systolic Murmur.—Gill (Australasian Med. Gaz., March, 1909) criticises the ordinary view of the actual causation of this murmur that it is caused by the vibration of the roughened mitral valve as the blood passes over it from the left auricle into the ventricle. He has recently investigated a case where the presence of a rough diastolic murmur and thrill at the apex led to the diagnosis of mitral stenosis, but at the autopsy no mitral stenosis, but great hypertrophy of all parts of the heart, was found. He also refers to the 46 cases collected by Dr. Phear, in which a presystolic apex murmur was present, but no mitral stenosis. The explanation which Gill offers of the causation of this murmur is as follows:-"The presystolic murmur is chiefly an auricular sound, or rather series of sounds; the murmur is usually compounded of two sounds, muscular and valvular-the first of which is the more important, while the second is not essential." He believes that in cases of mitral stenosis with a pre-systolic murmur the contraction of the auricle is not single, but multiple: "That a series of short contractions occur one after the other, culminating in one powerful contraction which occurs immediately before the contraction of the ventricle; that each contraction produces a sound which is conducted by the ventricular muscle to the apex." The valvular component of the pre-systolic murmur is represented by the mid-diastolic murmur of mitral stenosis. In confirmation of these views tracings are shown from the jugular and epigastric pulsations of a man, æt. 53, with old-standing mitral stenosis. "All the tracings have the same characters—viz., that the ventricular diastole is entirely occupied by a series of small waves, which even continue during the systole of the ventricles. These waves in the jugular can only be due to the contraction of the right auricle." K.

Therapeutic Value of Radium .- MacLeod (Practitioner, May, 1909), in discussing the therapeutic value of radium, speaks of the results he has obtained from its use in lupus vulgaris. On the whole, these results have been disappointing. It was found possible 10 cause the apparent disappearance of the nodules of lupus by the use of radium, but in nearly every case recurrence supervened. This was especially marked in those cases where the disease involved the mucous membrane of the nose and mouth. In these cases relapse. after temporary improvement, occurred.

The Treatment of Tinea Tonsurans.—Sutton (Amer. Journ. Med. Sciences, March, 1909) relates certain investigations which he has carried on with regard to the treatment of ringworm of the scalp. With some difficulty a white rabbit was infected with a small-spored ringworm obtained from the hair of a four-year-old patient. One of the two patches resulting from this infection was subjected to an eleven-minute exposure from a Piffard model cancer tube at a low vacuum, the window being placed 6 cm. from the area. Ten days later, there being no perceptible reaction, a second exposure of 12 minutes was given. Fifteen days later the hairs became loosened, and denudation was complete at the end of a week. One-half of the bald area was then thoroughly covered with the follewing mixture: Iodine crystals, 1.75; potassium iodide, 1.25; goose grease, 25. Some time later a portion of each half was excised and submitted to histological examination. Practically no inflammatory changes were found, but the iodine mixture was seen to have penetrated to the bottoms of practically all the follicles in the treated area, and to a considerable depth in the appended glands. Quite a number of fungi remained in the cavities, along with small portions of broken hair cuticle. The other patch, which tions of broken hair cuticle. The other patch, which had not been submitted to the X-rays, was treated with the iodin-goose grease mixture, heat and friction being employed. Half-an-hour later a 2 per cent. solution of mercuric chloride in goose grease was applied. This application was repeated twice, at intervals of a week, and a fortnight later the patch showed decided signs of improvement. Similar experiments were carried out on other rabbits, with the result that the area treated by the drugs alone appeared to improve quite as fast and quite as satisfactorily as the area depilated by the X-rays. Similar good results were obtained in the cases of five children, where the microsporon was the infecting fungus in each case. Dr. Sutton believes that goose grease is superior to other fats as a skin penetrant. The powerful effect of the iodine, followed by the mercuric chloride, is due, not to the individual action of either agent alone, but to a third, mercury iodide, an extremely active and powerful, but relatively unstable, salt, which is formed at the points of contact.

Treatment of Tuberculosis .- Stern (Cleveland Med. Journ., March, 1909) gives his clinical experience of the use of Koch's tuberculin for the treatment of tuberculosis of bones and joints during 18 months. The method of using the tuberculin which he has adopted is that advocated by Trudeau. In this method one begins with minute doses, 1/10,000 or 1/1,000 of a milligram of Koch's tuberculin, and gradually increases it till the dose has reached 1/100 of a milli-gram. This dose is continued for some weeks, and then the treatment is begun over again. As a guide for the size of the dose, the interval between the doses and the increase in the amount of the dosage, every discoverable objective and subjective symptom of the disease is made use of. The method is purely clinical, and the object is to avoid altogether all reactions of any kind. Dr. Stern lays great stress on the importance and value of thus being able safely to use the tuberculin treatment under the guide of clinical symptoms, since regulation by the investigation of the opsonic index is too costly to permit of its use in general practice. While using the tuberculin it is important not to neglect any of those other methods of anti-tuberculous regime, such as fresh air, good food, and physical and physiological rest. When used in this way Dr. Stern has found the treatment an invaluable aid. His cases have done better than they would have done without its use. They have responded quicker, and have been discharged in less average time than ever before. Complications have either been avoided, or, when present, have subsided on its continued exhibition. This has been especially noticeable in his adult or older cases, in some of whom the gain in weight and strength has been truly remarkable.

### NOTICES TO CORRESPONDENTS, &c.

Correspondence requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Beader," "Subscriber," old Subscriber," etc. Much ognfusion will be spared by attention to this rule.

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necessarily for publication but as evidence of mentity.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

should be addressed to the Publisher.

M.D. (Staines).—Caravans can be obtained of several London firms—either with or without the necessary horse or horses. For healthy and vigorous persons the outdoor wandering life forms a complete and wholesome contrast from ordinary domestic forms a complete and wholesome contrast from ordinary domestic one must be prepared for a certain amount of exposure. In wet weather tempers are apt to be strained, and there is little shelter to be had except within the van. It is well to have advice from experienced travellers as to the best routes to follow. The holiday passed on wheels is apt to be costly, but it is a pleasant change for folks of the outdoor temperament.

MEDICAL MEN AND THE TAX ON PETROL.

International metrical Congress, together with the notes and lodging arrangements at Buda-Pesth in our issue for April 28th.

MEDICAL MEN AND THE TAX ON PETROL.

MR. LLOYO GEORGE has again refused to grant a rebate on the petrol used in motor cars by medical men, but he has offered to receive any deputation, which is representative, on the subject receive any deputation, which is representative, on the subject will wait on Mr. Lloyd George with the object of learning, amongst other points, in the words of Mr. Chlozas Money, "on what principle a special incom: tax has been imposed on doctors who use motor oars in the course of their professional work."

J. W. B.—We have searched the official Medical Register, and also the Medical Directory for 1909, and cannot find the name. You may assume, therefore, that he is "unqualified," or has been struck off the Register.

DR. Hr. G. is thanked for his communication. The suggestion in the second part of his letter has been acted upon.

S. M. (Manchester).—It looks suspicious, but it would be right to swait developments.

## Meetings of the Societies, Tectures, &c:

Wednesday, May 19th.

Medical. Graduates College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Mr. Collier: Clinique (Surgical).
5.15 p.m.: Lecture: Sir Thomas Oliver (Newcastle): Some Unusual Features of Lead Poisoning.
NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's NORTH College (Mr. R. P. Brooks).

ROYAL SOCIETY OF MEDICINE (DERMATOLOGICAL SECTION) (20 Hanover Square, W.).—5 p.m.: Dr. Louis Wickham: Demonstration of Radium Therapeutics.

MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Chenies Medical). 5.15 p.m.: Lecture: Dr. J. Mackenzie: A Demonstration of Graphic Methods for the Investigation of Cardio-Vascular Conditions.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gyneco-logical Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Oarson); Z.Rays.

ROYAL SOCIETY OF MEDICINE (EPIDEMIOLOGICAL SECTION) (20, Hanover Square, W.).—6.30 p.m.: Paperr: Dr. John Brownlee: Hanover Square, W.).—6.50 p.m.: Paperr: Dr. John Brownlee: Certain Considerations on the Causation and Course of Epidemics. Mr. M. Greenwood, jun.: The Problem of Marital Infection in Pulmonary Tuberculosis.

Society of Tropical Medicine and Hydiene (1 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Adjourned Discussion Street, Cavendish Square, W.).—8.30 p.m.: Adjourned Discussion

on Beri-Beri. Communicated by Dr. A. T. Stanton: A Paper on Beri-Beri of Historio Interest, written by Dr. J. Bontius, of Batavia in 1629. Captain C. A. Gill, I.M.S. (Labore): A Note on the Epidemiology of Pneumonio Plague.

MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Cheales Street, W.C.).—4 p.m.: Mr. Stuart-Low: Clinique (Ear, Nose, and Throath)

and Throat).

NORTH-EAST LONDON POST GRADUATE COLLEGE (Prices of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

CENTRAL LONDON THROAT AND EAR HOSEITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. W. Wingrave: Clinical Pathology.

EVERIDGE, J., M.R.C.S., L.R.C.P.Lond., House Surgeon at King's College Hospital.

GRUNTLETT, E. G., M.R.C.S., L.R.C.P.Lond., Senior House Physician at King's College Hospital.

Gleson, H. E., M.B., B.Ch.Oxon., House Surgeon at King's College Hospital.

siclan at King's College Hospital.

GIBBON, H. E., M.B., B.Ch.Oxon., House Surgeon at King's College Hospital.

GIBBON, H. E., M.B. Lond., F.R.C.S.Eng., Junior Resident Resident Medical Officer at Queen Charlotte's Hospital.

HUGHES, BASH., M.B., B.C.Cantab., M.B.C.S., L.R.C.P.Lond., Junior House Physician at King's College Hospital.

MCCALL, J., L.R.C.P.Edin., House Surgeon and Secretary to the Hertford County Hospital.

MCDONALD, C. E. W., M.R.C.S., L.R.C.P.Lond., House Accoucheur at King's College Hospital.

PORTER, CHARLES, M.D., C.M.Edin., M.R.C.P.Edin., Medical Officer of Health of Marylebone.

PRESCOTT, N., M.R.C.S., L.R.C.P.Lond., House Surgeon at King's College Hospital.

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Superintendent.

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Committee Office, 6 Waterloo Place, London, S.W.

Reckett Hospital, Barnsley.—Surgeon. Salary, £150 per annun
with board and lodging. Applications to R. F. Parsey, HoSecretary, 8 Regent Street, Barnsley.

Suffolk District Asylum, Melton.—Second Assistant Medica
Officer. Salary, £160 per annum, with board, turnish:
apartments, attendance, and laundry. Applications to the
Medical Superintendent.

### Births.

MAILEE,—On May 12th, at Rookdene, Alexandra Park Road, Musve Hill, the wife of William Maller, M.B., C.M., of a son. MITOHBLL—On May 13th, at Eastgate House, Guildford, the wife i Arthur M. Mitchell, M.D., Cantab, of a son.

### Marriages.

MEILO—HAWKINS.—On May 11th, at St. Lawrence Church, inster, Peter Paul Elliott Mello, son of Mr. and Mrs. Mr. of "Rosebank." Sidley, Bexhill, to Margaret Emily. & daughter of F. M. Hawkins, M.D., of "Chapmans," Upming

### Beaths.

BOULTON.—On May 15th, at Seymour Street, Portman Squinon, in his 68th year, Percy Boulton, M.D.Edin., M.B. London, after a long and serious illness. London, after a long and serious illness. Don May 15th, of pneumonis, William Ferris, M.D., Assimedical Officer, Middlessex County Asylum, Wandsworth Corlection, uged 34.

WHITTLE.—On May 2nd, at Las Palmas (Canarics), Edward Growth Wilson, On May 15th, at Dean's Grove, Guildford, Lieurer Colonel James Wilson, R.A.M.C., son of the late Thomas Wilson, aged 73.

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### THE MEDICAL PRESS AND CIRCULAR

"SALUS POPULI SUPREMA LEX."

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No. 21.

### Notes and Comments.

The Burial of the Still-born.

WE have received some interesting communications regarding our "Leader" of May 12th on the Cornish burial scandal. The fact that in the year 1909 both the manager and the

gravedigger of a public cemetery are in the habit of burying as "still-born" infants who have survived birth from a few days to several weeks shows the necessity of supervision as well as of legislation in such matters. Abuses in connection with still-birth burials have been recognised ever since the registration of deaths became compulsory and general. So long ago as 1866—a correspondent points out—Mr. F. W. Lowndes exposed these abuses, first in Birmingham and afterwards in Liverpool. His writings attracted the notice of the Home Office, and it may be safely assumed that they formed the basis of the Burial Acts Amendment Act of 1874. It is somewhat startling to find the salutary provisions of that measure regarding the burial of the still-born absolutely a dead letter in the year 1909, and it is to be hoped that the Home Office will take steps to prevent the recurrence of scandals such as those exposed by the recent inquest at Ludgvan. The disclosures made upon that occasion are of a most serious nature, and in our opinion suggest the desirability of a general inquiry into the conduct of cemeteries with regard to this and other administrative matters.

and Still-births.

It is no less disquieting to find that The Midwife a midwife who has been raised to the dignity of a State recognition should know nothing as to her duties and responsibilities under the Burial

Acts. At the Cornish inquest the certificated midwife concerned admitted that she had never read the regulations with regard to still-births. Failing the presence of a registered practitioner at the birth, a midwife is entitled to grant a certificate that the child was still-born, upon which the body may be buried. So serious a view is taken by the law of any abuse of the power, that a false declaration involves a penalty of £10, or an alternative of no less than seven years' penal servitude. With this possibility in view, it is curious that persons should be found ready to run so much risk for reasons that must necessarily be inadequate. Good nature and the desire not to offend clients or neighbours by adding to their perplexities are easily-understood motives, but at the same time they are apt to lead their owners into a deadly pitfall. It is to be hoped that the Central Midwives Board will firmly grasp the moral of the Ludgvan case, and ascertain once and for all that midwives are acquainted with their duties and responsibilities under the Burial Acts before they receive their certificate of fitness to practice midwifery.

A Human Reptile.

THE frequency of the crime of procuring abortion must be much greater than is commonly supposed. Not only by the nature of the crime must an enormous number of opera-

tors, male and female, escape detection, but when from time to time one of them is laid by the heels, the police are generally able to show that the criminal has enjoyed a long period of immunity, owing to their inability to get evidence sufficient to justify a prosecution. One of these vile creatures was tried at the Old Bailey last week, owing to the death of one of her unfortunate victims from septic peritonitis. The charge of murder was put forward, but the jury, for some reason which certainly does not appear, reduced the crime, as they had power to do, to manslaughter, and of this they found her guilty. The prisoner, although only thirty-nine years of age, had been watched by the police in connection with abortion for no less than twelve years, and they had received numerous complaints about her. Her husband, now dead, who is said to have been a doctor, but was probably a low type of charlatan, was convicted of performing an illegal operation in 1898, and sentenced to seven years' penal servitude. Her servants had on three occasions found parts of children's bodies in the grate, and they gave evidence of many women having stayed in the house at one time and another.

The Home Office and

MR. JUSTICE DARLING, in passing sentence, said what was true when he remarked that the jury had taken Abortion. a merciful view of the prisoner's crime in not finding her guilty of murder, and we have no doubt that had she been

a man they would have convicted her of the major crime. In the judge's opinion, people like the prisoner deserve the death penalty, and we thoroughly agree with him. A woman who systematically carries on the vile practice of abortionmongering year in and year out deserves not the slightest particle of pity or leniency. Single occurrences under special conditions may deserve to be treated differently, but regular and oft-repeated crime should put the perpetrator beyond the pale of mercy. Mr. Justice Darling sentenced the prisoner in this case to ten years' penal servitude, and made the curious remark that "he would have passed a longer sentence upon her but for the fact that it might be reduced by the Home Office to the kind of stereotyped sentence which they allowed." Are we to understand from this that the Home Office have fixed rules for over-riding long sentences?

We have over and over again pointed out the stupidity of long sentences in many classes of crime, but we can hardly imagine that in the case of a notorious and inherently wicked prisoner of this type they would reduce any sentence, however long, which a judge imposed on her.

WE have not much experience of

"Do Doctors our contemporary the Christian Disease Commonwealth, but our attention Children ?" has been drawn to an article in last week's number bearing the ungrammatical headline, "Do Doctors Disease Children?" We are tempted to follow that journal in its distortion of the English language by asking if it thinks it "Christians" its readers by making itself party to any such atrocious suggestions? Happily the reply to the query is dealt with by a Miss Margaret McMillan, who, though she professes herself an anti-vaccinationist, writes with uncommonly good sense on the subject. She says :- "If this is true, the medical profession is a fiendish one. and fiendish persons alone would uphold it. Is it not time for all of us anti-vaccinators to put away such fearful suspicions, and to admit that, though wicked men may get into this profession, or into any other, yet the profession itself is not a fiendish one? It numbers in its ranks many quiet heroes. The average member of it is utterly incapable of the crimes sometimes laid to his charge." She goes on pertinently to point out that diseases come from dirt, ignorance, and unhealthy conditions of life, which doctors are doing their best to combat, and that vaccination is an unpleasant alternative to hygienic measures which people will not take for themselves. We may truthfully say of Miss McMillan that she is the first anti-vaccinator we have met with who seems to have studied her subject, to be tolerant and broad-minded, and to be animated by that charity that speaketh not evil.

Honone.

A SAD case was inquired into by the A Prophet, Halifax Coroner last week, in which not Without a Sowerby woman who during her last illness had no other attendance than that given by a local herbalist,

was found at the post-mortem to have died of peritonitis. The coroner said he did not purpose to call any further evidence, but the jury objected, saying they thought "Dr." Culpan, the herbalist in question, should be given an opportunity of giving evidence. The coroner said he did not think it worth while, as the case was obviously one of death from natural causes. The foreman then took up the cudgels and asked if a post-mortem was necessary, for the people of Sowerby had known "Dr." Culpan for thirty or forty years and had great confidence in him. "They felt," he said, "that of late years the coroner had taken the idea that he was a mere quack-a man who was going and coming. He had, on the contrary, grown up amongst them and was a very respectable man." This is certainly a new definition of a quack-a man who comes and goes-and for our part we should hardly feel justified in entrusting our lives to a man merely because he had grown up amongst us; but, as the coroner pointed out, the real question was whether the woman's life could have been saved by proper medical treatment.

### LEADING ARTICLES.

THE MEDICAL DEFENCE UNION.

For nearly a quarter of a century the duty of collective medical defence has been conducted by an effective professional body. During that period the work that has been accomplished has more than justified the energy of the self-sacrificing labour that has created and maintained that most necessary organisation. The first of these bodies-there are now three of them in active work-was the Medical Defence Union, and we turn with pleasure to their recently-issued Annual Report and Statement of Accounts for the year 1908. It is encouraging to find that the average increase has been maintained by the accession of 478 new members during the year under report, while the number on the register reaches the considerable total of 7,761. The financial condition of the Union is satisfactory, and they have at their back the sum of some £10,500 in the shape of a guarantee fund to fall back upon in any great emergency. The assets at the end of the year amounted to some £4,000, which should form the nucleus of a solid reserve fund as the years go by. The greater part of the expenditure has been due to legal costs, namely, £2,081 28. 11d. The Union would benefit greatly were our costly and cumbrous system of legal procedure simplified and were cheap law conferred upon British citizens. One of the features of the year has been the conclusion of an arrangement with the Yorkshire Insurance Company, whereby any member of the Union may take out an indemnity insurance covering his law costs in any action in which he may be concerned as defendant for negligence qua practitioner. The practical value of the Union to members is well expressed by the President, Dr. Stamford Felce, as follows:-"The (legal) cases are varied, but each would, if left to the individual practitioner to deal with, have cost him considerable anxiety, expense and trouble, which have been saved him by reason of his membership. Numerous letters of cordial thanks and gratitude for services rendered have been received from members during the year. These letters have served to show that the value of the legal assistance afforded has been greatly appreciated by those who have sought it, and have more than ever proved the necessity for the existence of the Union. It is difficult to imagine what would have happened if the practitioners concerned had not been able to secure such aid, advice and timely help; it can be said with absolute certainty that many of them would have been greatly harassed and seriously embarrassed." The Union is fortunate in the possession of two officials with an unrivalled experience of medico-legal questions in the persons of the secretary, Dr. A. G. Bateman, and the solicitor, Mr. W. G. Hempson. From the report of the latter we learn that 128 cases were actually carried through and completed, in addition to the very large number of instances in which advice was given, the matter settled out of court or otherwise disposed of. Of the 128 cases, 45 were within the metropolitan area, 70 in the provinces, 4 in Scotland, 2 in Ireland, and 7 in Wales. Of the completed cases, 40 were for libel and slander taken or defended on behalf of members; 25 were to defend

actions brought against members for malpraxis. It is interesting to find that accusations under the last-mentioned heading are frequently heard of for the first time when the plaintiff has been proceeded against in the County Court for recovery of medical fees. In one particular instance a patient brought a charge of negligence against his medical attendant who had failed to diagnose a condition discovered by operation. The case was decided against the plaintiff who, in spite of his apparently good financial position, was unable to pay the taxed costs of the action, amounting to £300. The Council of the Union regarded extreme measures as justifiable and instituted bankruptcy proceedings, but as the debtor's assets were returned as under £20, the whole costs, amounting to £350, fell upon the Union. This experience emphasises a grave defect in British law, where a man of straw is enabled to bring an action-it may be even vexatious and frivolous to a degree—but the unfortunate defendant has to pay enormous costs in spite of his having won the suit. The moral, however, so far as medical men are concerned, is that by the simple payment of ten shillings a year the member in the case referred to was saved a heavy pecuniary loss, besides having his action conducted in a skilled legal manner. The annual report of the Union affords some interesting reading, and practitioners will hardly fail to gather various suggestive hints of practical value from its perusal. In conclusion, we strongly urge all medical men who are not already members of the Medical Defence Union, or of one of the companion societies, to lose no time in joining an organisation of such conspicuous value and comfortable prudence.

### CURRENT TOPICS.

### Workhouse Babies.

We recently had occasion to refer to the criticism passed by the Local Government Board on the figures and conclusions with regard to infantile mortality in workhouses set out in the Minority Report of the Royal Commission on the Poor-laws. A good many individual protests of a similar type seem to be forthcoming, and the impression made on us is that the zeal of the minority seems to have carried them further than the actual ascertainable facts justified. But we are glad to see that the matter is arousing real interest and that guardians are actually bestirring themselves to find out how far their own institutions are at fault. This is a healthy sign, and we hope each board throughout the country will do the same. A special report by Dr. Dodson has been presented to the Wandsworth Guardians on the infantile mortality in the Wandsworth Workhouse, in which it is shown that the mortality in the first week of life for infants bern there is 24 per 1,000, which is little more than half of the average 42 per 1,000, as given by Mrs. Sidney Webb in a letter to the Times. Many of these deaths Dr. Dodson attributes to pre-natal and maternal conditions, and as the mothers have been poorly nourished, have often been dosed with noxious drugs, and have suffered terribly from mental worry, he does not regard this fact as surprising, and indeed it is not. Taking these considerations into account, he thinks there is nothing to be ashamed of in a death-rate of 24 per 1,000 in the first week of life. Mrs. Webb had pointed out that proper quarantine accommodation should be provided for newcomers, but Dr. Dodson says that with forty or fifty young children arriving a week the proposition is obviously impossible and verges on the ridiculous. On that point we are not sure that we agree, as the question is one which could be solved if sufficient accommodation of the kind were provided by the guardians, though to do so would be a matter of no small expense. It is more doubtful if the expense and trouble would give adequate results, for the problem of quarantine is a most complicated one if it is to be dealt with thoroughly and logically. At any rate, Dr. Dodson seems to be justified in his conclusion that workhouse mothers and children are better fed, better clothed, and better cared for in every way than among the poorer classes outside, and the guardians were satisfied with the report.

### Preserved Sausage.

THE interesting question, When is a sausage not a sausage? was before the justices at the Newington Sessions last week in an appeal by G. F. Hayward, pork-butcher, of Mayfair, against a conviction by Mr. Mead, sitting at Marlborough Street Police Court, imposing a fine of 40s., and £5 5s. costs, for selling a certain article of food-to wit, pork sausage-not of the nature, substance and quality of the article of food demanded by the purchaser. A Westminster sanitary inspector had bought some sausages from Hayward which proved on analysis to contain 22.4 grains of boracic acid to the pound, and Mr. Cribb, public analyst for Westminster, and Dr. F. J. Allan, medical officer of health for the same city, gave evidence that boracic acid was unnecessary and injurious, that its presence could not be detected by the consumer, and that its danger lay in concealing and arresting decomposition which was just about to begin. Mr. Cribb admitted in cross-examination, however, that ten or twelve years ago the majority of sausages contained boracic acid. For the appellant, counsel submitted that boracic acid was a necessary ingredient in the preparation of sausages, that some preservative, such as salt or saltpetre, was always used, and that the purchaser was in serious danger if no preservative was used. Dr. Klein gave evidence, saying that he had undertaken experiments for the National Federation of Meat Trades' Association, and that he had actually recommended them to use 26 grains of boracic acid per pound, as otherwise the sausages would not keep good for twenty-four hours. Another witness went so far as to say that a commercial sausage without boracic acid is not a sausage, and that the proper proportion is 35 grains to the pound. In the end, the chairman decided to reserve his judgment and to state a case for the High Court if desired. Now this matter is one of great public importance, for sausages are a favourite food of all classes, they are peculiarly liable to have all sorts of material used in their manufacture, and the amount of illness traceable to sausages is by no means small. It must be a great temptation to a butcher whose meat will no longer keep fresh to mince it for sausages and put in a little boracic acid as a preservative, though it is hardly credible that fresh meat made into sausages

will not keep for twenty-four hours. In face of the decision against putting boracic acid and other preservatives into milk, butter and cream, it is hardly possible to see how the appeal can succeed.

The Forthcoming Tuberculosis Exhibition.

A VALUABLE object-lesson is being prepared by the National Association for the Prevention of Consumption in the shape of a Tuberculosis Exhibition. The meeting will be held appropriately in the East End of London, for it is there that the disease claims its greatest toll of victims. The show will be opened by the Right Hon. John Burns, M.P., President of the Local Government Board, at the Art Gallery, Whitechapel, on June 2nd. It is announced that while the scientific aspect of the subject will not be neglected, the Exhibition will be chiefly of a popular and educational character. By the help of diagrams, models, actual specimens, and other means, the nature of the disease will as far as possible be impressed upon visitors. The medical profession will cordially approve this practical attempt to fight the enemy, especially as the power of such exhibitions upon the popular mind has been abundantly proved in America, and more recently by Lady Aberdeen's campaign in Ireland. One important fact about the forthcoming Exhibition is that no charge will be made for admission. further details can be obtained from the Organising Secretary, Dr. H. Hammond-Smith, 20 Hanover Square, London, W.

### The Indian Medical Service.

An interesting correspondence between the Secretary of State for India and the Governor-General of India with reference to the taking of measures for promoting the growth of an independent medical profession in India has just been published. Lord Morley, in August, 1907, called the attention of the Governor-General to a despatch of Lord George Hamilton in 1900, which expressed the opinion that it would be of great benefit to India generally that medical men should establish themselves in private practice in the country in the same way as they do in other parts of His Majesty's Empire without entering the Medical Service connected with the Army. The government of India, after a long investigation of the subject, have arrived at the conclusion that the advance in the direction indicated in the Secretary of State's despatch must be gradual, and should be made only as really qualified candidates become available in India, while a sufficient number of civil appointments should be reserved to provide for the economical employment of the war reserve of the Indian Medical Service, while it seems somewhat anomalous that nearly all the civil practitioners in India are drawn from the military medical service, there are two considerations which should carry great weight in an attempt to upset the arrangement. The first is that wider experience gained by military doctors in civil employ prevents them from "rusting," and this is of incalculable benefit to the Army; and the second is that the prospect of civil employment, with its enhanced remuneration, attracts a number of the best intellects in the profession to a service which might otherwise be none too popular. The popularity of the Indian Medical Service has been severely tried by many recent changes, and we are bound to warn Lord Morley that any hurried or ill-considered measures may seriously affect what has hitherto been considered as one of the best openings for the talent of the profession.

### The Bacillus of Whooping-Cough.

It is not a little curious that the identity of the micro-organism of so common a disease as whooping-cough has not been absolutely established. The recent researches of Klimento, however, appear to have confirmed the organism obtained in pure culture by Bordet and Gengon in the year 1906. The bacillus in question is small and short, with rounded ends; it stains feebly, and when stained with carbol methylene blue it shows polar granules. It is non-motile, aerobic, and of feeble growth, on a special medium of glycerin, potato, gelatin and blood. After several generations, however, it acquires the power of growing fairly well on other media. It appears in large numbers in the sputum, almost in pure culture during the early catarrhal stage and a few days after the whoop is established, that is to say, at the period when it is important, and at the same time most difficult to make a diagnosis. In later stages of the disease the bacillus gradually disappears, being crowded out by other organisms, notably that of influenza. Intratracheal injection in monkeys and young puppies gave rise to a malady resembling whooping-cough without the whoop, and the specific organism could always be recovered from the nasal mucous membrane, and in some cases from the lungs and blood. Out of 76 human cases the organism was cultivated only in five early cases; but it was found in stained preparation in about 80 per cent. The evidence of the identification of the specific pathogenic bacillus probably appears to be almost, if not quite, complete. It is to be hoped that further investigations will lead to the discovery of some remedy for this fatal scourge of modern civilisation.

### Consumptives as Neighbours.

THE preaching of the infectivity of tuberculosis has as its inevitable sequel an increasing dread of proximity of the disease. In Ireland it would appear that the public are at last learning that tuberculosis is infective, since, if accounts are true, consumptive patients are in some parts of the country treated almost as lepers. It is difficult to carry conviction that the disease is not communicated, if certain very simple rules be followed, though such is, of course, the fact. The fear of infection has recently shown itself in the strong opposition shown by the inhabitants of Sutton and Dalkey, two seaside villages near Dublin, to the conversion of disused coastguard stations into socalled "Health Homes" by the Women's National Health Association. It is natural, in the present state of public feeling-or public ignorance-that the proximity of such institutions should depress the value of property, and we cannot wonder that property owners should therefore object. cannot, however, believe that any injury to the public health would result, so long as such "homes" are properly managed. It is true the public are left in doubt as to the exact use to which the homes are to be put, and a little more frankness on this point might have smoothed the path of the Association. The Association is doing such excellent work that it is a pity it should be hampered by misunderstanding.

Mercer's and the Orthopædic Hospitals Bazaar.

By the time this article is in print, his Excellency the Lord Lieutenant will have declared open the large Bazaar which is being held this week in Dublin in aid of Mercer's and the Orthopædic Hospitals. The Bazaar promises to be a high success, and it is reported that it will provide attractions of all kinds on a scale which was not attempted even at the many large bazaars for which Dublin was so celebrated some years ago. The Bazaar will be held, as is usual with such functions, at the Royal Dublin Societies' premises at Ball's Bridge, and they have been very fully decorated for the occasion. The proceeds of the Bazaar will be divided between the two hospitals mentioned above, and we are sure that each one of our readers will wish that the funds of these most deserving institutions may largely benefit by the enterprise. At the moment we write one thing alone seems to be needed, and of that there seems to be good promise. On several former occasions wet weather has proved a source of considerable loss to the promoters, but on this occasion the elements promise to be different. We hope that our country readers will be able to patronise the Bazaar in large numbers, and will do what they can to benefit the funds of the two hospitals.

A Hint for the Mental Hospital.

It is a sound principle before making a start in a fresh undertaking to review carefully the experiences of others in a similar direction. That attitude, we understand, is being adopted by the Asylums Committee of the London County Council, at the suggestion of Dr. Henry Maudsley. As readers know, our confrère has generously contributed £30,000 towards the special mental hospital which they have agreed to build, and he has recently advised the Council to inspect the Berlin and Munich hospitals before completing their scheme. The wisdom of such a step is obvious, and it is understood the Asylums Committee will advise the Council to despatch an official to Germany and to other places where any useful information is likely to be gained. The importance of the attempt to treat mental diseases in their early stage is so supremely great that it would be a pity to waste time and energy in acquiring experiences that can readily be guarded against by avoiding the pitfalls that have been disclosed by previous explorers.

### PERSONAL.

Dr. EDWARD LIVEING has resigned the office of Registrar to the Royal College of Physicians, a post he has occupied for the last twenty years. At the meeting of the Council last week a resolution was unanimously passed recording the faithful and efficient manner in which Dr. Liveing had discharged the duties of his office.

THE Danish Royal Scientific Society has admitted as a foreign member Dr. Dreyer, Professor of Pathology in the University of Oxford.

THE new out-patients' department at the Royal Portsmouth Hospital was opened on May 11th. This department has been built at a cost of £4,000, given by Mr. Woolmer White, of Havant.

At a meeting of the Welsh University Court, held at Mold on May 14th, Sir Isambard Owen was again re-elected Senior Deputy Chancellor, and Sir John Williams was elected Junior Deputy Chancellor.

The fifty-seventh Annual Meeting of the Governors of the Hospital for Sick Children, Great Ormond Street, was held at the hospital on May 13th, the Duke of Fife, President, in the chair. The income for the year was £24,188, and the expenditure £23,474. The midsummer fair and  $f\hat{c}te$  at Olympia will be opened on June 23rd.

THE seventy-seventh Annual Meeting of the British Medical Association will be held at Belfast from July 23rd to July 37st, 1909. The President-elect is Sir William Whitla, M.D., LL.D., Professor of Materia Medica and Therapeutics, Queen's College, Belfast. The Presidential Address will be given by him on July 27th.

THE Address in Medicine will be given by Dr. Robert W. Philip, M.D., F.R.C.P.Edin., Physician to the Royal Infirmary, Edinburgh, and the Address in Surgery by Mr. A. E. J. Barker, F.R.C.S., Professor of Surgery, University College, London.

SIR JOHN W. BYERS, M.D., Professor of Midwifery and Diseases of Women, Queen's College, Belfast, will give the Address in Obstetrics, and the popular Lecture will be delivered by Dr. J. A. Macdonald, Physician to the Taunton and Somerset Hospital, Chairman of the Representative Meetings.

SINCE the unanimous election of Dr. R. Arthur Prichard, of Conway, as the Chairman of the Carnarvonshire County Council, a widespread movement has been initiated to present to him a public testimonial in recognition of his long and honourable career in the public service of North Wales. It is proposed that the testimonial shall take the form of an address and a motor-car suitable for his practice.

At the invitation of the Lord Mayor of Leeds (Alderman F. J. Kitson) a number of local gentlemen interested in the Health Congress, to be held in Leeds during the third week in July, met at the Town Hall on May 18th to arrange for the entertainment of the Royal Sanitary Institute and the Royal Institute of Public Health.

THE Annual Dinner of the Pharmaceutical Society of Great Britain was held on May 18th at the Holborn Restaurant, under the presidency of Mr. J. Rymer Young. Among those present were Viscount Hill, the Right Hon. Thos. Lough, M.P., Sir Dyce Duckworth, Mr. T. H. Idris, M.P., Mr. R. Winfrey, M.P., Mr. P. Snowden, M.P., and Mr. W. S. Glyn Jones.

THE MAYOR OF NEWPORT (Mr. Graham White) was on Wednesday honoured by his colleagues of the British Dental Association at the annual meeting of the South Wales Branch at Llanelly by the presentation of a silver salver to commemorate his appointment as the first dental mayor in South Wales.

### A CLINICAL LECTURE

ON

### THE FEEBLE-MINDED AND THEIR CARE. (a)

By GEORGE H. SAVAGE, M.D., F.R.C.P.Lond.,

Consulting Physician and Lecturer on Mental Diseases, Guy's Hospital; Consulting Physician to Earlswood Asylum, &c.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

ANOTHER point is that injuries may arrest development, but you must be very careful in analysing the history of the injury. I think there are very few children who have not had injuries to the head. A mother discovers that her child is weak-minded, and sets out hunting for a cause. I always think of my old teacher, Sir William Gull, when I was propounding something or other. He said, "Savages and lunatics explain; wise men investigate." And one finds it easy to explain by a fall on the head things which have no relationship to it whatever. There is no doubt that certain feeble-minded individuals owe their feeble-mindedness to inability to develop, due to opiates or a little gin given to keep them quiet. I am sure I have seen cases of that kind. Sometimes there are individuals who overgrow their nervous system and never regain it. It has been said of giants that they are like tall houses, the top storey is used as an attic. At all events, I meet with these tall individuals who outgrow their nervous system or nervous power, and are permanently weak. I suppose that every month a huge lad of 15 or 16 years of age comes into my consulting-room, and, seeing it has a door of about 6ft., he has to stoop. The majority of these never become anything but feeble-minded.

that every month a huge lad of 15 or 10 years or age comes into my consulting-room, and, seeing it has a door of about 6ft., he has to stoop. The majority of these never become anything but feeble-minded.

What are the varieties of defect in the feeble-minded? They may be general, or they may be special. It is well to look upon some such as absolutely deficient in partscof the mind. Others are permanently wanting in the power of direction of what they have. Take the simplest first. A child comes into the world an apparently normal child. He is nursed by the mother, or brought up by hand. At 18 months the mother is surprised that the child will not attempt to walk, and speech is wanting. Another six months go past, and the mother still finds the child does not walk. Yet, apparently, there is nothing wrong about the legs. It crawls rapidly about the floor, but will not walk; and is fairly good. Another 6 or 8 months go by and the child is beginning to totter about, but does not talk. It slowly begins to talk at about 3 or 4 years of age, but only imperfectly. There you have a deficiency in the most human attributes—the erect stature, and speech—as evidences of defect. I should say that they are the most important gauges of defective development which is likely to end in permanent feeble-mindedness. These children are very subject to rages, so that a little thing will upset the balance. They often are restless sleepers; not infrequently, they have night-terrors or troubles of that kind, and they are long learning the ordinary conventions of life, so that they eat clumsily, they do not keep themselves clean, they do not dress themselves well, little acts like buttoning their clothes are difficult, and yet those children are only looked upon as backward. They have learnt truth and honesty. They may have done a certain amount of book work, and here it is interesting to note the deviations that may occur. Some of these may have special ability of a limited kind. For instance, I am told that this child who could not wa

speak every language for a moment or two; if you looked at this person and addressed her in English she would look back at you and repeat your English, word for word, whether it was our English or the American variation of it. The same was true of German or French. She would repeat and reproduce words, but with no knowledge. And it is so with a certain number of these individuals, they can reproduce, but cannot develop. Now I will give an example of one who when he reached 12 or 13 years of age it was considered that he should be sent to a trade. At 14 he was apprenticed to a tailor. Daily for three years he went to work. At the end of that time his father thought he would be able to take an improver's position. He was sent to a tailor, who had not taught him, and knew nothing about the years he had served, and he was sent home at the end of 24 hours as useless. He could use the needle, and that is all he could do. He was put to another trade, that of bootmaker. He could hammer in the nails, and do little mechanical things of that sort, but give him leather and ask him to shape a boot—no, he could not do that. Yet he was a bright boy, he was a smart-looking youth, polite, and had a nice way, and it was thought that he might do for a kind of errand boy or messenger boy in a shop. No good. He was perfectly willing, but nothing could be made of him. Yet you could talk to him about most things in a way, but he could do nothing usefully.

Now and then cases of this or a similar kind are legally important. Take an example. I was asked to see a young lady who was coming into considerable property, and I was asked to report as to whether she was fit to manage her affairs. I found her a well-dressed girl of 20, who answered me in a bright way, and I thought it seemed hard lines to bring her to me. I said to her, "Do you read French?" "Yes." I gave her a French book, and asked her to lead it. I said, "Now about money matters," and at once I saw a flush over her face. "Would you mind doing a little sum?" She could not add 2 and 2 together; there was as complete a defect of understanding the relation of numbers and figures as could be imagined. I gave her a handful of money to count; she could not do it. That sort of defect is not very uncommon. Little things of that kind may interfere with the world's work, and the person may have to be considered feeble-minded. In such a case no education will benefit. Little temporary defects, which can hardly be called weak-mindedness, are amusing in a way, such as want of power of spelling ability. We find individuals everywhere who may pass muster, but are rather "soft." You not infrequently see them in villages. They form a class which, if allowed to breed, breed weak-mindedness to a certainty.

With regard to the treatment of such people, if they can be induced to do agricultural or mechanical work, well and good. It used to be thought it was good to get them into the Army and Navy, and if they were wasters it was thought to be good to get them into cavalry regiments. But the majority of them proved to be deserters before long. The training and the discipline of a service, and the discipline at sea, where they cannot get away very well, has an extremely good influence in keeping them out of mischief, and making them mechanical units. They do not become anything more than that.

more than that.

A further development, which you may say differs materially, is that of the inebriate. This matter has

<sup>(</sup>a) A Lecture delivered at the Polyclinic, London, on Thursday, May 8th, 1909.

been considered by the Commission—that is, the establishment of colonies for these various people, that there should be a colony for inebriate men, for inebriate women, for epileptic youths, for epileptic adults, and for the wasters, liars, thieves, tramps, and the rest. That is all very well, but there is the other side of the matter. Since I wrote this article people have appealed to me, thinking I had influence, which I have not, because, they said, their property was being seriously injured by the establishment of colonies for the feeble-minded in their neighbourhood. And one can well understand that colonies are extremely useful, but in England it is difficult to find the right sort of place in which to put them. In Belgium there is the oldest of all colonies, a place called Gheel, "The City of the Simple," where for over 700 years the Belgians have been in the habit of sending their insane and weak-minded, and their failures. In this out-of-the-way district there is a central receiving depot, and there are 15 or 16 little villages scattered all over the place, where these people are looked after. But we have not got places like that in England, and we cannot transport them. A certain number of these people are greatly benefited by religious institutions, such as convents.

Not long ago I saw a girl who was a Roman Catholic, and there is no doubt that if she had been at large she would have got into trouble, almost certainly moral trouble, but by getting her into a well-conducted convent she was controlled. She was easily led, and I think she will probably follow the religious life and be all right. In the same way the Church Army does excellent work. And there are one or two colonies in England which are supported by private doctors. There is one in Sussex, where there are eight or ten houses on a farm of 800 or 1,000 acres, and in each of these houses there is a head, and there are several youths of feeble mind who are being directed and kept out of mischief. The whole future treatment of the feeble-minded depends on the utilisation of these colonies. In a very large number of these cases success is only partial. Moral defects are more trying to deal with. We have to recognise that there are organic liars and organic thieves, and that honesty is a thing which has to be taught. The child comes into the world with the feeling that anything it can touch is a part of itself, and it is a slow acquisition to learn that things which it can touch do not belong to it. A large number never learn it at all. What am I to do with these thieves? The Government now sends the young thief to a kind of training prison, where, for a term, he can be kept under strict discipline, and it is hoped he will reform. A certain number are reformed. But the question is whether you are to treat these feeble-minded thieves as criminals, as sinners, or as sufferers, and I think a mixture of the two is desirable. One does not want punishment to be revenge, neither does one want the person who is a sinner to feel that he is in no way responsible, for if you encourage that, you weaken all chance of improvement. Many years ago in America I attended a Prison Congress, and I was surprised to find that in that democratic country they felt it would be the best possible thing for every person who had been convicted of anything, from pilfering to being drunk more than three or four times, to be segregated for the rest of his life.

Sexual morality, the control of the sexual passions, is very much wanting in these feeble-minded. If you go to any of these homes for the feeble-minded, for women, you find a very large number of mothers of illegitimate children, and, of course, it is all-important that such individuals should be separated. You have the morally and intellectually weak, who have given way, and who are certain to become the mothers of still weaker or worse individuals.

So there are thieves who have to be punished to a certain extent, and training will have a great effect. As far as moral defects are concerned, segregation and control are essential

The treatment of the feeble-minded, so far as drunkards are concerned, is one which I have not time to speak of now. Retreats are certainly useful for those who are organically drunkards; nothing will stop that. Everything has been tried, and there are brands plucked from the burning by all sorts of means—by drugs, by

the Salvation Army, certainly by hypnotism, and by these inebriate retreats. But I think we have hardly got so far in social evolution to allow the drunkard necessarily to be put on one side. Where will you draw the line between the dipsomaniac and the habitual drunkard? There are a certain number of dipsomaniacs who are wonderful men, and it would be a pity for them to be segregated

In the training of simple-minded girls, who are simply weak-minded, the same lines must be followed which I spoke of with regard to boys—occupation, interest, and constant observation. One of the greatest dangers is that of one child teaching evil to other children. Music, drills, gymnastics, and games are very important; a simple out-of-door life and simple diet are best; the majority of these simple-minded individuals require not only simple diet but no stimulants. As long as they are under age you can do fairly well what you like with them, but when they get older and it becomes a question, if they have property, of making them Chancery patients, difficulties may arise. There are many advantages if you can make a patient a ward of the Court of Chancery. There is a girl coming into considerable property; she is feeble-minded, and nothing more. Nobody could certify her. She does not understand money or the value of things at all. If she came into her fortune almost anybody could get it away from her. But is one going to prevent her from marrying? I shall try to make her a ward of Court, so that it would be a misdemeanour to approach her with the idea of marriage, without the consent of the Court, which, of course, would not be given.

Various avocations have been suggested for them. The present rage is to make every feeble-minded boy a poultry farmer or a fruit farmer. But there is a limit to that. If you get a boy that takes a real interest in it and makes his own hen-coops, it is all right; but he is not trustworthy. He falls into the lines of that definition which I gave. He could not, alone and unaided, earn a living for himself. In the case of these weak-minded individuals, one thing which is constantly tried and will be tried to the end, if they are wealthy, is that they will be sent round with a tutor to see the world. In some cases it does them good. One result I have seen from that has been satisfactory, but it cannot be advised—that is, one of these young men had a serious illness and married the nurse.

Next with regard to epileptics. There is no doubt about the gravity of the disease, especially if it commences in quite early life. There are several epileptic school colonies now. There is one at Lingfield, of which I am Honorary Physician. They have got several hundred children who are epileptic, but neither im-becile nor idiotic. They are educable children children from various parishes all over England. They are sent down at very low rates, where they have a perfectly good life. But you will never make them more than feeble-minded. They all have to be seen by me before they go to the colony, for me to decide that they will improve by education. First, they are living in houses of only one floor, so that they cannot fall downstairs; there are no dangers from lakes, ponds, or railways. Their diet is almost purely vegetarian; no stimulants. Their senses are educated more than their so-called mind. They have object-lessons and drawings; they draw and describe. They are carefully drilled; they have music and musical drill, and are taught singing and harmony. They have a certain amount of bromide, but not much; the quantity is reduced compared with the quantity they were taking before they were admitted. The fits decrease, and the children improve in a remarkable way. They will never become normal. The overseer says: "They will go on working as long as I am looking after them, but when I stop looking they stop working." When they have to leave school they are additions to the permanently feeble-minded class; they are individuals who have to go either to the workhouse or to the infirmary. The destination is that the epileptic group of feeble-minded is a very unfortunate one.

So there is a certain class of feeble-minded people who will never be anything else; but there are grades and degrees of feeble-mindedness. There are these weak-minded epileptics who are taught to do certain

mechanical things, and lead fairly happy and certainly healthy lives under restricting conditions. We have also to remember that there are such things as backward or even feeble-minded children who may suddenly ward or even teeble-minded childles was and become normal. Therefore another difficulty arises, and one must hesitate in condemning every feeble-minded child as permanently feeble-mined. It has been said that some of our greatest imaginative poets have been dullards at school, and have been looked upon rather as fools; and I remember one boy whose salvation depended on a fit. He was a weak-minded youth, and his father gave him up as hopeless. He had a series of epileptic fits, which seemed to break the spell, and in a few years he was in advance of his fellows, having had no more fits. There are very few backward children who really become normal, and the essential of all things is early recognition and early treatment.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for nest week will be by Professor H. Huchard, M.D., of the Faculty of Medicine, Paris. Subject: The Clinical Forms of Arterio-Sclerosis."

### ORIGINAL PAPERS.

### SUPRA-PUBIC PROSTATECTOMY. (a)

By G. P. NEWBOLT, F.R.C.S.Eng.,

Surgeon, Royal Southern Hospital, Liverpool,

In dealing with the subject of supra-pubic prostatectomy, I do not wish to enter into the question of whose operation it is, whether Freyer's or M'Gill's. (a) There is no doubt that it is a good operation, and that Freyer brought it into the position which it now holds in surgery. Again, I have practically no experience of perincal prostatectomy or of the combined operations of supra-public and perineal prostatectomy, and shall not, therefore, deal with them. My first point is, Under what circumstances should the operation of supra-public prostatectomy be advised? and before deciding this we have to consider the questions of mortality and of the actual relief given. Now, the mortality in Freyer's cases is low, about 8 per cent.; but he has been fortunate, and is an expert in this branch of surgery. I do not think the general surgeon who only does these operations occasionally will get the same results as Freyer has published. Escat gives a mortality of 18 per cent. in 164 cases, which I should think is likely to be the general average, unless the cases are selected. Personally, I have not been the cases are selected. Tersolarly, I have been heavy. Therefore, in advising people concerning this operation, I have put the facts plainly before them, and in several cases they have preferred to put up with present discomfort rather than run the risks involved.

I am speaking now more especially of cases in which the trouble has been rather an inconvenience than anything else. I have operated upon nine cases, and three died as a result of the operation; these were all hospital cases, and with one exception men in a very poor and broken-down condition. Death resulted from hæmorrhage in one and from uræmia in the other two. Another case came back eighteen months later with cystitis and stone, and died from bronchitis after a second cystotomy; four others were in good health some time after operation, and the fifth is convalescing. I have found no difficulty in carrying out the operation practised by Freyer, and whenever a definitely enlarged prostate has been present have got it out easily. The larger the prostatic mass, the more easily it enucleates: those which give trouble are the little, hard, fibrous ones, which are not suitable for removal by the abdominal routeonly it is not always easy to be sure of their nature beforehand. There is no doubt that, if possible, the

patient should be under strict observation for some time before one performs the operation. His urine should be tested carefully and the percentage of urea determined. It is also as well to wash the bladder out if cystitis be present. If there is difficulty in getting the catheter in, it may be better to drain suprapubically until things have quieted down.

Now, though I have so far only operated upon some nine cases, yet during the last few years I have seen a large number of cases of enlarged prostate, and from them have gained a good deal of information. One point is this: that, given a man with an enlarged prostate of some years' duration, and giving rise to some measure of obstruction, his life is an exceedingly uncertain one, and the following are good examples of this:-

(t) Six months ago I saw a man, æt. 63, in consulta-tion with a view to prostatectomy. He had had retention several times, and there was a large amount of residual urine, but he could pass his urine himself in the intervals of his attacks. He had an enormous prostate, which could be easily felt bimanually. His urine was acid (sp. gr. 1010), and his pulse was regular. Altogether he seemed to be a very suitable case for operation, and was admitted for that purpose; but uræmic symptoms came on directly after admission, and he died nine days after my first seeing him. It was a typical case for operation as far as the prostate was concerned.

(2) Three years ago, I saw a gentleman, æt. 72, who had suffered from retention for some five weeks. There was difficulty in getting a catheter in. However, I happened to have a coudé which passed easily, and he was content with this, and would not entertain any operation. Six weeks later I heard he died somewhat suddenly.

(3) Five years ago a man was admitted under my care to the Royal Southern Hospital with hæmaturia and retention from an enlarged prostate. His urine was drawn off, and he was taught to pass a soft catheter. He died suddenly in the night, half an hour after he

had emptied his bladder with the catheter.

Besides these examples, I have had a number of cases sent into hospital under my care with a view to operation which have developed uramic symptoms, and died of advanced kidney disease. The man, therefore, who gets retention early in his disease, and whose operation is done whilst his kidneys are healthy, is lucky inasmuch as he has a good chance of recovery; but the operation on a hospital patient with advanced kidney disease is about as promising as that performe! in the old days on a case of strangulated hernia of five or six days' duration. I have often congratulated myself on the fact that I did not touch either of the three patients whose cases I have quoted, for without doubt they all would have died soon afterwards. The result would naturally have been put down to the operation. An early operation would most probably have prolonged life, and, if so, most certainly would have made it more comfortable. But there is another side to the picture. A man may have an enlarged prostate giving rise to much inconvenience, and yet he may go on for years, dying eventually from some other complaint. A good instance of what an elderly man may stand is the following:—Some years ago I was awakened at 2 a.m. by the strains of a military band returning from Aldershot. With difficulty I got to sleep again, and urgent knocks at my front door failed to rouse me. Not until my telephone bell rang at 7 a.m. did I respond to an urgent call to attend to the bandmaster of the band which had so rudely disturbed my slumbers. I found him suffering from acute retention, and bleeding from attempts made to catheterise him. Supra-pubic aspiration at once relieved him, and I was able to pass a catheter later on. Two years ago I again saw this man (who was then 78) for a second attack of retention. After a week's catheterisation he again recovered control, and is well at present. Now, he is not a very healthy-looking man; he suffers from bronchitis, and it would be a risky thing to remove his prostate.

It is a curious thing how tolerant the bladders and

urethræ of some men are, whilst those of others are offended at the slightest liberty. For instance, one man gets gonorrhœa, which gives endless trouble and finally culminates in a prolonged gleet, a stricture, or a stiff joint; another speedily gets rid of his trouble and suffers no after-effects. The same with an enlarged prostate: one man gets cystitis after the passage of his catheter, though he has taken the usual precautions to keep it aseptic; the other moistens his catheter with his spittle, passes it, and is no whit the worse. Again, the hospital patient is usually in a worse condition than the man of means; he has been more exposed and has roughed it more. As an instance of this, I may mention three cases of diabetic gangrene for which I amputated through the middle of the thigh. The two hospital patients died; the private patient made a good recovery, though the other foot had been operated upon and though there was a very large amount of sugar in his urine. It

(t) A prostate weighing 5\(\frac{3}{2}\) ounces removed from a man, \(\pi\)t. 60\(\frac{1}{2}\), met on-cerned.
The patient remains well as far as his bladder is concerned.

appears to me, therefore, that though we may lay down rules for advising these patients, yet we have to take all the surroundings into consideration. What, then, are the indications for operation?

- (1) Complete retention and catheter life in an otherwise healthy man.
- (2) Frequency of micturition rendering life unbear-
- able and coming on at an early age—say at 60.

  (3) Hæmorrhage from the prostate, profuse in
- character and recurring at intervals.

  (4) Occasional retention, with difficulty in the passage of, or inability to pass, a catheter.

In all of these conditions I should strongly advise operation unless some other disease contra-indicated it.

In cases in which there is pain and discomfort in the perinæum or where there is occasional dribbling of urine I should let the patient decide whether he will have what I tell him is a serious operation done. should only advise it if he were in good condition, with normal urine.

I have advised against operation where there was I have advised against operation where that was frequency in the daytime in a clergyman, but not sufficient to prevent his doing his duties, and no necessity for the use of a catheter. Speaking generally, I do not believe in operating if there is a suspicion of malignant disease.

This brings us to the question of the diagnosis of malignant from simple enlargement of the prostate. This is often a matter of great difficulty. In the first place, malignant disease is far more common than is usually supposed, and though, when it was a question of simple treatment with a catheter,

etc., a mistake was not a very serious matter, nowadays an operation done under these circumstances will lead to great disappontment. I should put the symptoms of malignancy down as follows:-Frequency of micturition, pain, hæmaturia, and loss of flesh, with the presence of a hard, enlarged, and possibly fixed prostate. Persistent pain in the lumbar region or sciatica is always suspicious, and we naturally examine the rectum to try and find the cause. prostate is nodulated or enlarged it looks suspicious, and we await developments. A very good instance of this occurred in a patient whom I saw with a double hernia and with interest leads to the control of the contr with intense lumbar pain. Examina-tion per rectum revealed nothing, no medicine relieved him (he was under a physician), and I was persuaded against my better judgment to do a radical cure on one of the herniæ, which it was thought might be the cause of the pain. His lumbar pain persisted, and a second rectal examination revealed a hard, somewhat fixed prostate, quite different from the condition found at the examination two months previously. He developed sciatica and died soon after. Another patient had sciatica, for which he was treated until an examination per rectum cleared up the diagnosis. The case of a man named Miles P. is one of the most typical I have seen. He was admitted with retention and a history of attacks of hæmaturia and pain in the back. On examination he had a large hard prostate fixed on the left side, and a cystoscopic ex-amination showed a white, glisten-ing outgrowth from the left side of the prostate projecting into the bladder. No operation was suggested, but he was taught to pass a catheter. Later on in the disease

the inguinal and also the femoral glands became enlarged. Now, operation in these cases is not going to bring any surgeon much credit, and the final state is worse, in my opinion, than if they are left alone, unless you can get cases in which the whole disease may be removed—and these must be very rare indeed. The picture of a growth fungating through a suprapublic wound which has broken down, with the concomitant dribbling of urine, is a thing to be avoided if possible. If in doubt, I should advise frequent examination and waiting, for the disease will very soon reveal itself, as it did in the case of the man whose hernia I operated upon; or an exploratory perineal operation with a view to removal by this route after H. H. Young's method.

With regard to the operation itself, Freyer's description can be read in his own words, and I shall only take some of the points which have impressed me. In all supra-pubic cystotomies the proper distension of the bladder simplifies matters immensely; whether it is done with air or boracic lotion I don't think matters. The Trendelenberg position helps (and here I may say that these remarks are intended more for the gentlemen who only occasionally do a bladder operation than for my expert surgical friends). When the bladder comes well up from behind the pubes it is

well up from behind the pubes it is easy to open it with a thrust of the knife, and thus time is saved—an important item in operations on old people. The edges of the bladder are secured with silkworm gut sutures to which forceps are attached, so (5) P that no forceps are put on the edges of the bladder itself. These sutures hold the bladder up and also serve as retractors. One next feels for the point of the catheter which has been passed, and determines the nature of the prostate to be enucleated. determines the nature of the prostate to be enucleated. So far I have chiefly used my finger-nail, but have found that, unless it speedily enucleates, the nail gets soft and rather handicaps one, especially with the little, hard, fibrous ones. I have also used curved scissors to snip away some pieces of tissue which my nail would not tear. I usually start the enucleation from the right side, working towards the left and using the right index finger. In most of my specimens a piece of membranous urethra shows; but I think the less of this removed the better, as otherwise one gets



(4) This specimen shows a piece of membranous urethra hanging down from the prostate. The operation was performed for profuse hæmorrhage arising from an uleer on the part projecting into the bladder. He is well four years after operation.

after-trouble. In the last case I did, no membranous urethra was removed. The gloved finger of the left hand in the rectum is of the greatest assistance. After separating the tumour, it is seized with forceps and drawn up to the opening in the bladder. If large, the opening must be extended; it is far better to close it after than risk bruising the edges and causing sloughing. Occasionally there is hæmorrhage, and it is as well to compress the cavity left by pressure with the fingers in the rectum from below and counterpressure from above. If this fails, hot saline may be of use; and failing this the bladder must be packed with gauze. These patients won't stand hæmorrhage, and I unfortunately lost a case from this cause. The prostate in question enucleated quickly and easily, and perhaps the fact that I wished to do a rapid operation led to disaster. I got the operation over and sent the patient back to the ward, where he commenced to bleed. My house-surgeon controlled the bleeding by packing the bladder and transfusing; but the shock of operation, with the hæmorrhage added, proved too much for my patient, and he sank some eight hours after operation. I feel that if he had



(5) Portions of a little, hard, fibrous prostate, difficult to remove.

been kept a little longer in the theatre this might not have happened. When satisfied that hæmorrhage has been controlled, all that is necessary is to fix a large rubber tube in the bladder and wash through with hot saline by means of a soft catheter passed down the urethra. By seeing that the tube fits the hole in the bladder accurately, the patient can be kept fairly dry. Wood wool makes the most comfortable dressing. At first I tried sponges frequently changed, but they speedily became ammoniacal, and the edges of the wound got encrusted with phosphates. The tube may be removed from the bladder about the fourth day, and irrigation kept up through a soft catheter passed down the urethra. Patients begin to pass urine naturally about the tenth day, and the wound closes any time after the third week In my opinion, the stouter the man the more difficult the operation, especially if, as is

often the case, he has a big scrotal hernia. The hard, fibrous prostate is the difficult one to remove; moreover, the result is not so good, as a cavity remains which does not contract like the one left by a clean enucleation, and the patient is liable to get a phosphatic deposit unless he is careful. This occurred in one of my cases, the patient returning eighteen months later with a phosphatic stone in his bladder. (To be concluded in our next.)

### Metropolitan Hospital.

THE festival dinner in aid of the Metro-The festival dinner in aid of the Metropolitan Hospital, Kingsland Road, was held on May 21st, at the Whitehall Rooms. Lord Duncannon presided, and among those present were Lord Howard de Walden, Mr. Henry Wagner, Mr. W. G. Raphael, Major S. Weil, Mr. C. J. Thomas, and Professor Hermann Gollancz. The chairman said that they must remember

that the institution was not only a poor one, but that it was in a poor district. The average expenditure amounted to £14,000, and the assured income from investments came to only a little over £500. There were in the hospital 113 beds, and on an average 105 had been constantly occupied during the past year. More than 300 patients had been sent to convalescent homes, and about the same number had been helped to procure surgical and other appliances. This year the hospital had to make special demands for repairs to bring it up to modern requirements. The cost was estimated at £8,000, and, in addition to the sum required for the ordinary working of the institution, there were also needed an isolation ward and a new nurses' home. It was announced that the total sum given in subscriptions at the dinner was £4,852 58.

An Anti-Tuberculosis Congress was opened at Athens on May 19th, the Crown Prince presiding.

### THE TREATMENT OF CHOLERA. (a)

By Major LEONARD ROGERS, M.D.Lond., F.R.C.P.Lond., F.R.C.S.,

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In view of the fact that the case mortality of cholera has certainly not been reduced in India during the last seventy years, the treatment adopted by older Indian writers is of great importance. I have carefully studied them, but can here only give a very brief summary. In the days of Annesley and Twining (1832) mary. In the days of Annesley and Twining (1832) copious bleedings and violent purges were universally used in all conditions thought to be inflammatory, which included cholera. Yet Twining, who bled so much in fevers, warns against its dangers in all but the very early stages of cholera. Moreover, the inevitable 20 to 30-grain doses of calomel was always tempered by full doses of opium in cholera by the physicians of that time. With these exceptions their treatment of the disease scarcely differed from that which has prevailed up to the present day. Thirty years later in the time of Morehead, Goodeve, and Macnamara, bleeding and large doses of calomel had been finally abandoned, while opium remained the sheet anchor in the precollapse stage of cholera, being now combined with astringents, such as acetate of lead and dilute acids. In 1893 Wall's book on the subject appeared, and his great experience emphatically endorsed the same line of treatment, while he also enthusiastically advocated the use of saline injections, which the antiseptic era had now rendered much safer than when they were first introduced by Mackintosh and Latta in Edinburgh in 1831.

THE GREAT VALUE OF OPIUM.

The one fact which stands out preminently from their writings is the universal opinion as to the great value of large doses of opium in cholera, the present comparative neglect of which is, I think, a retrograde step. In the premonitory diarrhœa there is general agreement that opium can cut short the disease, while in the more advanced stage of copious evacuations Wall advises tr. opii min. 12 with acid suph. dil. min. 10, to be repeated in two hours if necessary. If rejected by the stomach he gave 12 minims of the liquid extract of opium subcutaneously, greatly preferring this to morphia, and found that in a large number of cases it prevented collapse after the onset of which it is too late for this remedy. Goodeve gave two grains of opium, or 40 minims of laudanum, while Macnamara used opium with acetate of lead or dilute sulphuric acid. For semetime past I have been giving morphia hypodermically to every other cholera patient admitted within the first two days of the disease with, I think, some benefit, but have not seen any approach to the invariable cures recently reported from Sylhet. Regarding the use of calomel in small doses there is much greater difference of opinion, Goodeve stating that it got its reputation owing to its doing no harm, while Wall condemns it as being altogether injurious. It is possible that the drug may help to re-establish the flow of bile as Annesley maintained, but I doubt if this is sufficient to counteract its dangerous purgative effects. If given at all it should be in \( \frac{1}{2} \) grain doses, repeated several

Camphor has also been recommended as a stimulant, especially in Paris, but its value is at least doubtful. The value of the long catalogue of other drugs which have been extolled is probably in inverse ratio to their number. The question of the use of alcohol in cholera is a very vexed one, many observers from Corgyn to Macnamara utterly condemning it, the lastnamed considering it to be "both theoretically and practically an unmitigated evil." Goodeve and Wall, bowever continuous recommend it in small does. The however, cautiously recommend it in small doses. The great objection to it appears to me to be its tendency to increase the vaso-motor paralysis, so that it is very rarely advisable in native patients, and only occasionally in Europeans who have been accustomed to its regular use. When given its effects on the pulse and blood pressure should be carefully watched. Ammonia may be substituted with greater safety.

Once the pressure has sunk to a very low point, or

(a) Abstract of Paper read before the Cholera Section, Indian Medical Congress, Bombay, February, 1909.

complete collapse has ensued, drugs are not only useless, because not absorbed, but become positively dangerous, as they accumulate in the alimentary tract, and later may enter the circulation during the stage of reaction in undesirable quantities. Either nothing but frequently repeated small quantities of water or ice may be administered, and the patient left to take his chance; or active measures to rapidly restore the ebbing circulation must be adopted, the following methods being available in the latter alternative. When the violence of the initial diarrhoea has abated. leaving a pulse of fair volume and a blood pressure of from 60 to 80 min. in natives, saline enemata of from one-half to one pint should be administered every two to four hours. In mild cases this will suffice to tide the patient over the threatened collapse, or to prevent its recurrence after revival by intravenous transfusion. If relied on a most careful watch must be kept for any further sinking of the pulse necessitating more active measures, because marked collapse may ensue at any moment, especially if renewed watery evacuations occur.
SUBCUTANEOUS INJECTIONS.

The next most simple measure is subcutaneous injections over the chest, axilla, or thighs, which appears to have been introduced by Wall, and has been largely used in India during recent years. About half a pint is usually injected in one or more places, and if any pulse remains it is rapidly absorbed. are two serious objections to this method. owing to the low vitality of the tissues in cholera, abscesses frequently follow in spite of great care in the administration. Secondly, my observations on the serum and specific gravity of the blood before and after cholera transfusion show that in any case requiring saline injections it is generally useless to administer less than three pints, while four are usually required to reduce the concentration of the blood to, or better a little below, the normal point; an amount which cannot conveniently be given subcutaneously. In all severe cases, therefore, we have to fall back on the use of intravenous saline injections, which unfortunately require considerable technical skill and time, seriously limiting their general applicability in India. Moreover, although the immediate effects in restoring the circulation and relieving the cyanosis, cramps and restlessness are simply marvellous: yet the ultimate results have hitherto been extremely disappointing, for only too often the diarrhea rapidly recurs, all the improvement being frequently lost within a few hours. Wall rightly insists that it should be repeated again and again, and mentions should be repeated again and again, and mentions success being attained after six transfusions, but admits that as many as 70 per cent. of his patients died. Goodeve remarks that "owing to no means having been found to keep the fluid in the vessels the method just missed being a great and glorious discovery." In my own experience, in conjunction with Captain J. W. D. Megaw, I.M.S., this method produced only a slight reduction in the mortality on account of the same recurrence of the diarrhoea which has baffled all previous workers, and intravenous injections were once more almost entirely abandoned at the Calcutta Medical College Hospital.

It then occurred to me that the failure might be due to diluting the concentrated blood by the normal saline solution (o6 per cent. NaCl.) which has nearly always been used, and that what was required was to replace the lost fluid, and at the same time maintain a high percentage of salt in the blood, which would tend to cause the osmotic current to carry fluid into the vessels, rather than allow it to escape from them. The remarkable success which has attended the intravenous injections of hypertonic salt solutions in cholera has already been recorded, and time will only permit me to mention that among 175 cases treated in the first nine months of 1908, during the very virulent epidemic then prevailing, the mortality, including all late moribund and complicated cases, has been only 33 per cent. or but little more than half the rate of several previous years, and that too although it was frequently impossible to transfuse as many as one should have liked. I must not omit to mention that all the hard work of carrying out this method has fallen on Captain Maxwell Mackelvie, I.M.S., who deserves the fullest credit for his successful labours. Favourable reports of its use in a few cases have also reached me from several quarters.

INTRAVENOUS TRANSFUSION.

The continuous method of intravenous transfusion of Cox should also be referred to, as it is reported to have given good results in his hands in Hong Kong. With the hypertonic solution used in Calcutta, namely, 120 grains of sodium chloride (with 3 grains of calcium chloride, owing to the frequent great decrease of the coagulability of the blood) to one pint, a single rapid injection of four pints usually suffices to permanently tide over the collapse stage, but in some cases it has to be repeated.

Owing to the technical difficulties of intravenous

Owing to the technical difficulties of intravenous transfusion rendering it inapplicable in India except in well-equipped and staffed hospitals I have devised a cannula for easy and rapid intraperitoneal injections, which has been used by the assistant surgeons and hospital assistants at the Campbell Hospital, Calcutta, in a temporary mat shed with earth floor, with an encouraging degree of success, under the superintendence of Major J. C. Vaughan, I.M.S., to whom I am greatly indebted for so kindly giving the method a trial under conditions which afforded a reliable guide to its general feasibility in India. It consists of a small silver-plated steel tube, with one end sharpened like a cork borer and a flange two inches above to prevent it slipping in too far. A blunt stiletto suffices for cleaning the tube when necessary. A small incision is made with a tenotome, or other narrow-bladed knife, through the skin and fascia of the anterior abdominal wall just below the navel, where the peritoneum is adherent. The tube is inserted into the wound, and with a boring movement can readily be made to enter the peritoneal cavity without any chance of injuring the intestines. From 3 to 4 pints can readily be run through in about ten minutes, the little operation being thus much quicker and easier than intravenous injections. If any pulse remain, the fluid is rapidly absorbed, so that it can be used in all but absolutely moribund patients, in whom immediate intravenous injection is essential. An abdominal binder applied after the injection which both slightly raises the blood pressure and facilitates absorption. The injections can easily be repeated through the same perforation, a superficial stitch and some collodion on cotton wool being afterwards applied. When a large number of cases have to be treated with a small staff, this method promises to be of great value.

TREATMENT OF URÆMIA.

Lastly, a few words remain to be said on the treatment of uramia. The post-mortem renal transfusions already mentioned led me to watch the blood pressure day by day in the reaction stage of cholera patients, with the result of showing that this complication most commonly occurs when the blood pressure does not rise above 100 m.m., while at higher ones urine is readily excreted. One man, with deep stertorous breathing of 42 to the minute and almost absolute unconsciousness, made a good recovery on his blood pressure being forced up from a little under 100 to 110 by hypodermic injections of adrenal and digitalin. Hot-air baths have also been of value once full reaction had been attained by large transfusions. Cupping over the kidneys should never be neglected.

In the time at disposal I have only been able to touch on the salient features of the treatment of this appalling disease. I venture, however, to hope that the hypertonic transfusion in collapse, and blood-pressure-raising treatment of the uræmia may prove sufficiently successful in other hands to do something towards removing the, not altogether unjust say, however, that it appears to me the profession in India require a little gentle stimulation in this direction." It would seem as if we had almost abandoned ourselves to despair in the matter of the treatment of cholera: doubtless, the task is beset with difficulties, but this should not depress, but rather stimulate, research, where the good of our fellows and the honour of our profession are so deeply concerned. The solution of the question, I repeat, is one which preeminently devolves upon men living in the endemic

area of cholera, and it is to us, therefore, that the profession in Europe naturally turn for information on these matters.

## THE ESSENTIALS OF PHYSIOLOGICAL HISTORY.

By DAVID FRASER HARRIS, M.D., B.Sc.Lond.,

Lecturer on Physiology in the University of Birmingham.

ABSTRACT OF LECTURE I.

The first of a course of three lectures on "The Essentials of Physiological History" was delivered in the Medical Theatre of Birmingham University on Thursday, May 6th, 1909. The lecture was fully illustrated by lantern slides of portraits.

Dr. Harris said his intention was to give in each lecture a concise sketch of the history of the growth of knowledge regarding such functions as the circulation of the blood, respiration, the action of the nervous system, digestion, secretion, &c., so comprehensive that those interested in biological history could have before them the views held from the earliest times up to the present day. As regards

DISCOVERY OF THE CIRCULATION OF THE BLOOD, undoubtedly William Harvey had many forerunners, the passage of blood through the lungs from the right to the left side of the heart having been described by Michael Servetus, the Spanish theologian and martyr (1546), M. R. Columbus (1550), and Andreas Cæsalpinus (1571). The lecturer pointed out that, until the seventeenth century, the term " circulatory system " would have had no meaning. Some notions were then given of what Hippocrates, Plato, Aristotle, Praxagoras, Erasistratus and Herophilus wrote or taught about the vascular system. The ideas of Claudius Galen (130-200 A.D.) were described in detail, because the Galenical was the only physiology which the schools of Europe had for about a thousand years. Galen believed in an ebb and flow in veins, but knew that the arteries contained blood, and taught that the blood passed from the right to the left side of the heart by pores in the interventricular septum. This "Galenical doctrine of the heart" was doubted by Vesalius (1543), denied by Servetus and Columbus, and completely disproved by Harvey, both in the fifth chapter of the "De Motu," 1628, and in his "Letter

to P. M. Slegel," of Hamburg (1651).

After Galen's death no fresh light was shed upon the vascular mechanism; his writings in Greek were the scientific legacy left by the Roman Empire to European medicine. He had editors, commentators by the hundred, but no research was done until the era of the Italian Renaissance. Mundinus, of Bologna (1315), and Berengarius, of Carpi 200 years later, both wrote text-books of anatomy and dissected the human body, which latter Galen had apparently not done; but no systematic account of angeiology was given till Vesalius published his magnum opus, the "De corporis humani fabrica" (Basel, 1543). With Vesalius we enter on the modern period of anatomy, as with Harvey of physiology. Vesalius, besides describing the whole human frame by means of beautiful illustrations, displayed the valves of certain veins, and held the nonporosity of the septum, but did not know of either the "lesser" or of the systemic circulation. M. R. Columbus, in his "De re anatomica" (1559), and Servetus, in his "Christianismi restitutio" (published 1553), both describe the pulmonary transit. Servetus and his books were burned at the stake at Geneva, by the order of Calvin, in 1553. The claims of Cæsalpinus were briefly alluded to, seeing that in Italy Cæsalpinus is regarded as the dis coverer of the circulation, and because in 1878 a

commemorative marble with an inscription to that effect was unveiled in the University of Rome. Though Cæsalpinus knew a good deal regarding portions of the circulatory system, and understood the "lesser" circulation, he did not grasp the system in the way Harvey did, and he did not demonstrate it, nor, as far as one can make out, did he succeed in teaching it to any one. Professor Filippo Pacini, in a letter published in the Lancet (October 14th, 1882), makes the following confession :- " I am bound to acknowledge that the glory of having demonstrated that discovery by every kind of argument or of fact belongs unquestionably to Harvey. If Cæsalpinus and Harvey were now living, it is certain that our scientists would consider it a duty to ascribe it to Harvey; but, both being dead, it is natural that Italian scientists would attempt to claim it for Cæsalpinus, and thus it is that Italy is still called the land of the dead." Fabricius, Harvey's teacher in Padua (1537-1619), though he wrote a monograph on the valves of the veins, knew no more of the circulation than Galen.

Dr. Harris then gave an outline of the life of Harvey, remarking that he had distinguished patients (amongst them King Charles I., and the Lord Chancellor Bacon), distinguished contemporaries, correspondents and opponents. The contents of the various chapters of the "De Motu" were then epitomised, and it was seen that, besides being an anatomist, physician and physiologist, Harvey was a zoologist, a comparative morphologist, and tried to be a histologist as well. He used his "perspicillar" or simple lens, wherever he could. Not possessing the new or compound microscope, he could not see the capillaries—the tubes leading from arteries to veins, but he inferred their existence as "porosities of the lungs" and "porosities of the flesh." Harvey made the capillaries a logical necessity; Malpighi made them a histological fact. Marcellus Malpighius, in 1660 in Bologna first saw them in the lungs of the frog. Leeuwenhoek, in 1688 in Delft, discovered the systemic capillaries in the tail of the tadpole and web of frog's foot. Dr. Harris then showed how the Rev. Stephen Hales studied the physical problems of the circulation ("Hæmodynamics," 1726), his forerunners having been Lower, Borelli and Keill.

The contributions to the physiology of the circulatory system by J. C. Arantius, A. M. Valsalva and Steno, having been noted, a summary was given of the advance in knowledge during the eighteenth century up to the work of Thomas Young and John Hunter.

A rapid epitome of the chief additions made during the nineteenth century closed the lecture.

### OUT-PATIENT'S ROOM.

ROYAL FREE HOSPITAL

Treatment of Chronic Ulcer of Leg. Under the care of Mr. WILLMOTT EVANS, M.S., F.R.C.S.

Amongst the out-patients was a man, æt. 62, with an extensive ulcer on his right leg, measuring 8 in. by 7 in., and extending nearly the whole way round the limb. It was deep, and the edges were thickened and in parts sharply cut and irregular. Mr. Evans said that the diagnosis of these chronic ulcerations of the leg was by no means always easy. It is customary nowadays to diagnose most of these ulcerations as arising from varicose veins, while the diagnosis of syphilitic ulcer of the leg is restricted to those cases in which multiple punched-out ulcers are found especially near the knee. With this view Mr . Evans

totally disagreed. Of course, he recognised that the ulcers last described were syphilitic in origin, but he felt sure that a very large proportion of the ordinary chronic ulcers of the leg were also due to tertiary syphilis. He did not deny that interference of the circulation of the limb produced by varicose veins favoured greatly both the origin and persistence of syphilitic ulcers, but he considered that the syphilitic virus was the true causa causans in the condition. Success in the treatment of these cases depended, in his opinion, on the acceptance of this view. It is not difficult, he remarked, to cure these cases of chronic ulcer of the leg if the patient can be confined to bed for a number of weeks, but the problem is by no means. so simple when it is required to effect a healing of the ulcer while the patient is still pursuing his ordinary occupation. The use of Unna's zinc dressing is of occupation. The use of Unna's zinc dressing is of great value in suitable cases, as it tends to prevent the venous engorgement caused by varicose veins, but the application is tedious, and many patients do not like it. To treat these cases successfully it must be recognised that three factors are present. We have, first the syphilitic virus; secondly, the venous congestion; and, thirdly, sepsis produced by the ordinary pyogenic organisms. The syphilitic taint must be treated by mercury or potassium iodide internally. He preferred mercury or potassium iodide internally. He preferred to trust to the iodide to remove the manifestations of the disease, but he considered that mercury was essential to prevent recurrence. It is also important to recognise the beneficial effect of both mercury and iodine when applied locally. The iodine is best used for local treatment in the form of a lotion of the strength of the tincture, diluted or not with water according to the smarting effect produced. On the whole, he considered the best mode of local treatment of these chronic ulcers was by powder. Most of the organisms producing the suppuration in the ulcer failed to develop if the wound can be made perfectly dry, and this can be brought about by the use of a suitable dry powder. The powder which Mr. Evans preferred consisted of the following: 10 grains of calomel, \(\frac{1}{2}\) oz. of oxide of zinc, and \(\frac{1}{2}\) oz. of "kieselguhr." This powder is extremely absorbent, and the presence of the calomel makes it also antiseptic and gives it an anti-syphilitic power. The wound is bathed at each dressing with the iodine solu-tion, and it is then filled with the powder. At the next dressing no powder is taken away, but the moist places are again dressed in the same way, additional powder being applied. The rapidity with which the wound becomes dry depends greatly on the care with which the dressing is conducted, but generally in two or three weeks the greater part of the ulcer has become perfectly dry and ceases to secrete any discharge. crust formed is not disturbed until in course of time it is thrown off, and healthy skin is found beneath it. Occasionally it happens that the healing is not complete, a small part of the ulcerating surface still remaining; this is treated similarly, and ultimately complete recovery should follow. All this time the internal treatment is continuing, and the leg should be rested as far as possible.

### OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

OPERATION FOR ACUTE APPENDICITIS .- MR. ARTHUR EDMUNDs operated on a man, æt. 20, who had been admitted suffering from abdominal pain. The patient was taken 48 hours before admission with colicky pain in the lower part of the abdomen, and vomiting, which former continued up to the time of his arrival at the hospital. The bowels had acted on the day of the onset of the attack, but not since, though he was usually regular in that respect. On admission he had but little pain, his temperature was 100°, and the pulse only 90; indeed, on his symptoms, without examining the abdomen, the whole case seemed apparently trivial, but the abdomen was motionless at the lower part and very rigid. The diagnosis in these cases, Mr. Edmunds said, was always important, as, in spite of all that has been written, the number of cases in which opera-

tion has been delayed too long is still large. When it is possible to make the diagnosis of appendicitis an operation becomes the wisest course in the absence of operation becomes the wisest course in the absence of any conditions which would prohibit any operation, and the question to be decided is simply when the operation is to be performed. Operating upon every case of appendicitis undoubtedly, he pointed out, means operating on many cases which would have recovered, without operation, and, were it possible to differentiate with certainty the type of appendicitis from which the patient is suffering, non-operative measures might be adopted in a large number of cases. This is, however, not possible, and surprises in the shape of grave disease, combined with trivial symptoms, are common even in the practice of surgeons. of the greatest skill and experience. As to the time of the operation, there is no doubt that in the quiescent period between attacks the operation is simpler, but stage is that drainage is necessary in cases which might have recovered sufficiently for an operation to be performed in a quiescent interval and the wound completely survived. On the other hand, a certain perperformed in a quiescent interval and the wound completely sutured. On the other hand, a certain percentage of these cases either have died or formed a localised abscess. Waiting for an abscess to come to the surface so that it can be opened extra-peritoneally is hazardous, as the risk of a general peritonitis following the efficient drainage of pus across the peritoneum is negligible; some operators are inclined to impose too severe a task upon the peritoneum and to enture without drainage cases from which a definitely suture without drainage cases from which a definitely infected appendix has been removed, and even in some While the where there has been actual gangrene. peritoneum is able in many cases to satisfactorily overcome the infection, results are more often disastrous when there is much pain at the onset, where the temperature or the pulse is high, or where the abdominal rigidity is well-marked and extensive; in fact, in all but those cases in which the objective and subjective signs are absolutely trivial, the sooner an operation is performed the better. It must be remembered, however, he remarked, that the surgeon is not dealing with certainties, but with comparative risks, and an operation is usually the safer plan.

In the present case the patient was anæsthetised, the abdomen opened in the usual manner, a small amount of free fluid mopped up, and an acutely inflamed appendix covered with lymph and bathed in a small quantity of free pus excised. Drainage tubes were passed into the flank, into Douglas's pouch, and down to the stump of the appendix, dressing applied

and the patient returned to bed.

When there is a large amount of free fluid in the abdomen it is better. Mr. Edmunds said, to drain by means of drainage tubes, when the affected area is small; as, for example, when there is a gangrenous hernia buried in the midst of coils of adherent intestine, it is better to leave the wound widely open and to pack it with gauze, care being taken to push the small intestine out of contact with the packing by interposing the colon or omentum as far as possible. Sitting the patient up in bed after the operation is a most excellent plan, but it must be done with careful supervision of the patient's pulse. The majority of supervision of the patient's pulse. The majority of patients, however, stand it perfectly well.

Ten days after operation the patient was making

an uninterrupted recovery.

### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

MEETING HELD MAY 13TH, 1909.

The President, Dr. HERBERT Spencer, in the Chair.

DR. T. W. EDEN read a paper on

THE OPERATIVE TREATMENT OF RUPTURE OF THE UTERUS, WITH AN ACCOUNT OF THREE CASES TREATED BY ABDOMINAL HYSTERECTOMY.

The author summarises the discussion on rupture of the uterus at the Obstetrical Society in 1900, introduced

by Dr. H. R. Spencer, who related four cases treated by gauze-packing, and advocated the use of this method in practically all cases. In 1901 Varnier recorded his experience of uterine rupture, condemned conservative treatment such as gauze-packing, and advocated abdominal section for removal of the uterus in all serious cases.

CASE I.-A case of rupture during version for transverse presentation in a ii.-para, æt. 29, at Charing Cross Hospital, on January 22nd, 1905. Rupture was complete, the placenta having passed into the peritoneal cavity. The placenta was removed by hand, the peritoneal cavity douched through the rent, which was and an attempt made to pack the rent, which was very extensive, with gauze. Fourteen hours after delivery, as there was evidence of fresh internal bleeding, the abdomen was opened, and free bleeding found from the edges of the laceration, which the gauze-packing entirely failed to control. The uterus was re-moved by the supra-vaginal method, the pelvic peri-toneum closed, and the vaginal portion of the rent then packed from below. The patient made a good

recovery.

CASE II.—A case of rupture during version with a vi.-para, æt. 33, at Queen Charlotte's Hospital, on April 10th, 1908. She had previously been twice operated upon, the first time for retroversion, the uterus being ventrofixed; the second time for extrauterine gestation; the pelvis was flat (c.v. 3½), and "pendulous belly" was well marked. The placenta had passed into the peritoneal cavity, and the rent was complete and very extensive. Three hours after delivery the abdomen was opened, and the uterus relivery the abdomen was opened, and the uterus removed by the supra-vaginal operation; vaginal drainage was employed, and the patient made a good

recovery CASE III.—A case of spontaneous rupture during the second stage of labour in a ii.-para, æt. 25, Charing Cross Hospital, January 17th, 1909. After a prolonged first stage, during which the membranes remained unruptured, strong labour pains set in, and the head advanced well into the pelvic cavity. The patient was then violently sick and immediately became collapsed; hæmorrhage occurred from the vagina, and on examination the head was found to have receded and could no longer be felt. Diagnosis of incomplete rupture no longer be felt. into the left broad ligament was made, and the fœtus extracted per vias naturales. A complete and very extensive rupture was then discovered; the pelvis was contracted (c.v. 31 inches). Abdomen opened three hours after delivery; the left ovarian artery was torn and had retracted while still bleeding, beneath the periods above the politic being. Hence we have the politic being the periods and the periods are the periods are the periods and the periods are and had retracted while still bleeding, beneath the peritoneum above the pelvic brim. Uterus removed by the supra-vaginal method, and vaginal drainage employed. The patient at first rallied after the operation, but died rather suddenly 7 hours later. At post-mortem examination fresh bleeding was found to have occurred from a tear of the bladder, which had not been noticed at the operation. at the operation.

In considering the general question, it is pointed out that the three risks associated with this accident are shock, hæmorrhage and sepsis. The author believes that deep bleeding occurs with greater frequency than has been supposed, and may be met with in both complete and incomplete rupture, although the risk is greater in the former. Cases of incomplete rupture have been described in which a large hæmatoma extending from the pelvis to the diaphragm has been found. The hæmorrhage which immediately follows the rupture usually ceases spontaneously, but recurrent bleeding is frequent, because uterine retraction cannot control it, and the bleeding may in part be extra-uterine. To control hæmorrhage is therefore an indication of the first importance.

About 50 per cent. of the mortality of uterine rupture is due to sepsis, the commonest form being acute uterine septicæmia and general peritonitis. The general mortality of uterine rupture at the present time is probably over 70 per cent. Many deaths occur within an hour after delivery, and this must be borne in mind in considering the results of operative treatment.

In estimating the mortality of methods of treatment, only cases occurring in series at lying-in institutions and treated by reputed observers have been considered. The mortality of expectant treatment is estimated by von Walla at 60 per cent.; by Kolomenkici at 61 per cent.; by Lobenstein at 92 per cent.; and by Munro Kerr at 90 per cent. Nothing like the good results from packing cited at the discussion in 1900 have been obtained by other observers. Thus Lobenstein has recorded 14 cases thus treated with a mortality of 92 per cent.; Draghiesco and Cristeanu record 6 cases, with 5 deaths; Klein has collated from various sources 65 cases, with a mortality of 52 per cent. In the author's opinion expectant treatment is only suitable for cases of incomplete rupture of moderate severity. In all severe cases, whether complete or incomplete, operation gives the patient the best chance of recovery.

Cases of extensive incomplete rupture may be quite as serious as those of complete rupture, and are attended by exactly the same risks. Abdominal section and removal of the uterus by the most rapid method possible is recommended because: (1) it is the only certain way of controlling hæmorrhage; (2) the uterus has frequently been infected previous to the operation; (3) if the uterus is left and the patient recovers, the risk of repeated rupture in a subsequent pregnancy is high. The mortality of this operation in skilled hands at the present time is estimated by Kolomenkici at 36.3 per cent., and by Klein (cases since 1890 only) at 37.5 per cent, thus comparing very favourably with the results of expectant treatment as estimated by the same observers. The importance of vaginal drainage is insisted upon.

Laparotomy and suture of the rent has been shown to yield a higher mortality than hysterectomy, and, for the other reasons stated, is not to be recommended.

In cases of extreme urgency it may be wiser, after opening the abdomen to control hæmorrhage, simply to pack the rent from above into the vagina, and remove the uterus a day or two later by the vaginal

Vaginal hysterectomy has not received an extensive trial. The objection to it is that it does not allow of that complete exposure of the field of injury which is required, and bleeding vessels may escape notice when operating by the vaginal route.

Dr. LIONEL SMITH read a paper on RUPTURE OF THE UTERUS.

A series of ten cases of complete rupture of the uterus, eight of which were treated in the General Lying in Hospital, and are the total number of

examples of this accident which have occurred among 10,989 deliveries during the last twenty years.

Case I.—Patient, æt. 24, iii.-para. Labour occurred at term; vertex presentation; craniotomy. Duration of labour, four hours. Rupture of lower segment of the uterus. Treatment: Stimulation. Result: Rethe uterus. Treatment: Stimulation. Result: Recovery. Subsequent labour nineteen months later; vertex presentation; forceps delivery on account of excessive violence of the pains. Duration of labour,

CASE II.—Patient, æt. 26, a primigravida. Cbstruction of labour due to contraction of the pelvis; vertex presentation. Duration of labour about five days; cephalotripsy. Rupture of the lower segment of the uterus. Treatment: The rent in the uterus was lightly packed with gauze. Result: Death in seven hours.

CASE III.—Patient, æt. 37, v.-para. Labour at term;

obstructed delivery due to contraction of the pelvis; vertex presentation. Rupture of the lower segment of the uterus, and escape of the fœtus into the peritoneal cavity. Treatment: Laparotomy, suture of the rent in the uterus, gauze drain per vaginam. Result:

Death in 2½ hours.

CASE IV.—Patient, et. 33, a primigravida. Labour at term; transverse lie; tonic contraction of the uterus; decapitation and cephalotripsy. Small rent in the lower segment of the uterus, extending upwards from a laceration in the cervix. Result: Death in 20

hours from peritonitis.

CASE V.—Patient, æt. 31, ii.-para. Labour at term; transverse lie; obstruction due to contraction of the pelvis; version and cephalotripsy. The placenta passed into the peritoneal cavity through a rent in the lower segment of the uterus. Duration of labour, 26 hours. Treatment: Stimulation. Result: Death in six hours.

CASE VI.—Patient, æt. 26, iii.-para. Obstructed labour due to hydrocephalus; cephalotripsy. Rupture of lower segment of the uterus. Duration of labour, 50 hours. Treatment: Stimulation. Result: Death in 12 hours.

CASE VII.—Patient, æt. 37, viii.-para. Twin labour, second child transverse. Duration of labour, 18 hours. Rupture of the uterus and escape of the fœtus and placenta into the peritoneal cavity. Result: Death immediately after the patient was admitted to the hospital.

CASE VIII.—Patient, æt. 40, x.-pate. term; vertex presentation; sudden and violent pains; forcens delivery. Result:

Death ten minutes after delivery.

CASE IX.—Patient, æt. 39, ix.-para. Labour at term; breech presentation; delay with after coming head. Large rent in the lower segment, small rupture and several fissures in the muscular substance of the upper segment; hæmorrhage into the peritoneal cavity. Result: Death immediately after delivery.

CASE X.—Patient, a multipara xi. Labour at term; breech presentation; obstruction due to cancer of the cervix; perforation of the after-coming head. Result: Death 11 hours after delivery.

Eighty per cent. of the patients were multiparæ, 20 per cent. primigravidæ. The cases are divided into two classes. In the first class the rupture was due to an abnormal excitability of the uterus, resulting in a great increase in the strength and frequency of the contractions together with a premature retraction, a condition exactly similar to that produced by the administration of ergot.

In the second class the rupture followed a prolonged and obstructed labour, and in some cases was possibly the result of perforation with an instrument, or was

due to some intra-uterine manipulation.

The symptoms presented by the various cases were shortly discussed.

The President (Dr. HERBERT SPENCER) said that, in considering the question of treatment, it was to be borne in mind that, although rupture sometimes occurred spontaneously and in careful hands, it arose for the most part in bad and dirty midwifery practice, and consequently the tissues were often bruised and infected, and many would die, however they were treated. He showed ten specimens of rupture from the museum of University College Hospital. In two of the cases abdominal hysterectomy had been performed, with a fatal result in each case from shock. Only one of the ten cases was a suitable case for supravaginal hysterectomy. Total hysterectomy was indicated in those cases which required the removal of the uterus, but in his opinion these patients were usually too much shocked to stand removal of the uterus by the abdominal route. He thought there should be no difficulty in controlling hæmorrhage after vaginal hysterectomy. He did not think Dr. Eden had made out a case for abdominal supra-vaginal hysterectomy as a routine method of treatment in com-plete cases of rupture of the uterus, and still less for

cases in which the peritoneum was not involved.

Dr. Hubert Roberts related four cases of rupture of the uterus which had come under his care. first of these was treated by plugging the rent, and she recovered. In the second and third cases the abdomen was opened and the rent sewn up with silkworm-gut sutures. One of these recovered, and three years later was safely delivered of a full term child at Queen Charlotte's Hospital. The fourth case died very soon after delivery, before it was possible to attempt any treatment. As to treatment, Dr. Roberts thought no hard and fast rule could be adopted. Packing might be advised in those cases where the rupture was incomplete, or the patient's condition so grave that abdominal section was out of the question. In other cases he thought the abdomen should be opened, but was of opinion that closure of the rent by sutures with drainage by gauze into the vagina would

yield equally good results as removal of the uterus.

Dr. Drummond Robinson stated that he had five cases of ruptured uterus under his care. One patient died shortly after rupture had occurred. In two cases the rupture was discovered after the delivery of the child. In both of these cases gauze-packing was employed, and they both recovered. In two other cases the fœtus was still in the uterus when the rupture was discovered, and abdominal hysterectomy was performed. Both patients died. The speaker was surprised that others had not alluded to this class of rupture in which the fœtus is still in the uterus, and delivery by the vagina is contra-indicated. He thought that in cases of this kind there was no option but to perform abdominal section and at the same time to remove the uterus.

Dr. J. S. Farebairn said he could speak only from a small experience of about six cases, in which, however, the three methods of plugging, suture of the rent, and abdominal hysterectomy had been tried. He thought that there was a place for all these forms of treatment, and that what should be aimed at was some means of recognising the cases suitable for each method. He had had three cases in which no operative treatment was done, two of which made as straightforward a recovery as any uncomplicated labour case. In one of them there was a rent through the posterior wall of the uterus which admitted three fingers, but there was no bleeding and a gauze plug was all that was required to prevent intestinal prolapse. In another case there was an extensive laceration into the left broad ligament, large enough to admit the whole hand, but not communicating with the peritoneal cavity. Nothing at all was done, and she made an uninterrupted recovery. A third case in which plugging was tried died in 24 hours. In the case in which hysterectomy was done, the child, which had been lying transversely, had escaped into the left broad ligament, and the placenta had been extended into the peritoneal cavity. Both child and placenta had been delivered by the outside practitioner before the patient was admitted. She was suffering profoundly from shock and was bleeding, so the abdomen was opened. The posterior layer of the broad ligament was torn into shreds, the ureter remaining as a bridge, and the uterine rent was so ragged that no other course than hysterectomy was practicable. This patient died a few hours later, as also did one mentioned by Dr. Lionel Smith, in whom partial suture of the rent and drainage was tried. These few cases exhibited such differences in symptoms that no one form of treatment would have been suitable in all.

Dr. EDEN and Dr. LIONEL SMITH replied.

### ROYAL ACADEMY OF MEDICINE IN IRELAND

SECTION OF STATE MEDICINE.

MEETING HELD APRIL 30TH, 1909.

The President, Dr. W. R. Dawson, in the Chair.

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PHYSICAL DETERIORATION AND A REMEDY. MR. J. B. STORY read a paper on the above subject. He remarked that there are no means of ascertaining with perfect certainty whether our population is physically degenerating or not. No statistics are available in the United Kingdom on this point. But it is known that urbanisation is increasing, and plenty of evidence exists to show that this tends to physical degeneracy. In support of this German statistics were quoted. Attention was called to the reports of three Parliamentary Commissions—(1) Inter-departmental on Physical Degeneration (1894); (2) A Royal Commission, Physical Training, Scotland (1903); and (3) Poorlaw Commission, whose report has been published this year. The first recommends a permanent anthropometric survey of all children and young persons, methodical physical instruction in all schools, and compulsory drill and physical exercises for all growing lads. The second makes almost identical recommendations, and the third, in a majority report, states that the most effective and thorough method of infusing into boys approaching adolescence a sense of discipline and self-restraint, both physical and moral, and of improving their physique for subsequent industrial occupations would be a universal system of a short period of military training. The author commented upon the utter lack of any systematic physical educa-

tion in Irish schools, and made the following recommendations, which were afterwards adopted by the meeting:—

(1) That a permanent anthropometric survey should

be made of children and young persons.

(2) That physical drill should be compulsory, in conjunction with a proper system of medical inspection, in all schools primary and secondary.

(3) That all boys between the ages of fourteen and eighteen, who are physically fit, should be compelled to belong to Boys' Brigades or Cadet Corps, or to attend classes where physical drill of a military character is conducted.

(4) That all youths at age of eighteen (rich and poor), who are physically fit, should be compelled to undergo

a period of military training.

Dr. FALKINER spoke from personal experience of the value attaching to boy-scouting. Apart from the question of a territorial army, military training would be in every way an advantage. He thought, however, that it was a good thing to let a boy feel some sense of responsibility at an early age, as he believed it led to the making of better men.

Professor M'WEENEY said he became convinced of

Professor M'Weeney said he became convinced of the great utility of compulsory military training when living in Germany. The habits of co-ordinated action, subordination and devotion to duty, and sacrifice of self, which a well-conducted course of military training conduced, are invaluable in the development of the individual and the nation. The lack of co-ordination was very marked in this country, and far too many of the children of the poorer classes were allowed to wander about the streets to acquire an anti-social character of mind, and to feel themselves as outside the scheme of things. The German system impressed him with the feeling of solidarity, and he considered the recommendations made by Mr. Story as most essential to the well-being of the State.

Surgeon-General BOURKE spoke of his experience of military training. There was a great difference between squads that had only a few days' service and those that had longer periods. He could assure them that even three months made a decided improvement, and the Swedish system had been found to be of great advantage. He had recruited at Preston and had rejected over half, but in agricultural districts, although the men had not the same intelligence, they were physically fitter. For scouting the town men would be much sharper.

Dr. M'VITTIE thought that the teeth were, perhaps, the most important indication of degeneration. He could not see how a man was going to stand hard work if he had not good opposing molars. It had been shown that 86 per cent. of the children in schools in Great Britain had very bad teeth, and he thought the figure showed that the race was degenerating at a rapid pace. If there was to be more prolonged physical drill, it should be under the control of the medical profession. If carried out under the control of those who knew something about the machinery of the body, it might be a great blessing. He was satisfied that well-handled compulsory service would benefit the country, not only physically, but mentally and morally, and do away with the reproach of the policeman all over the place, but there was a danger of letting the matter be rushed by enthusiastic but ignorant persons.

Dr. Nolan spoke of the good results of the Swedish

system in his asylum in Downpatrick.

The PRESIDENT said he had been converted to the doctrine of compulsory military service by a residence in Germany. The average young German, previous to the age of military service, was a slouching, round-shouldered person, but afterwards was well set up, vigorous, and manly looking. It had been argued against compulsory military service that it took the male population from their occupations when they should be learning them, and retarded the development of the country, but he thought the progress of Germany did away with that argument. The great advantage of early training was that it got a boy at the stage when he combined the self-indulgence of the child with some of the force of a man. It was a critical stage, and drill would be the salvation of the young men of the

Mr. STORY replied.

GENERAL ANÆSTHETICS BILL.

Dr. KIRKPATRICK read a paper dealing with the General Anæsthetics Bill now before Parliament. paper discussed the events which have forced this matter recently on the public attention, and also showed the efforts which have been made in former times to check the mortality from anæsthetics. Dealing with the present Bill, the writer opposed the proposed exclusion of dentists from the ranks of the anæsthetists. This opposition was based on the high position of the dental profession, its past record in connection with the administration of anæsthetics, as well as on the curriculum at present enforced on its students. The onus of proof that the safety of the public demands this exclusion lies with those who would enforce this exclusion, but so far it would appear that this proof is not forthcoming. In the writer's opinion, the course of instruction laid down for dental students of the Royal College of Surgeons in Ireland is quite sufficient to permit the dentists of the future to be entrusted, with perfect safety to the public, with the important duty of administering anæsthetics.

Dr. CRAIG said that Dr. Kirkpatrick stood almost alone in his defence of the dentists who were not also registered medical practitioners. Although in favour of the Bill, he thought they might legislate in far too many directions, and so overload the student. The dentist who had taken the trouble to become a qualified medical man would not be touched by the Bill. only those who had not taken the trouble to go through the ordinary medical curriculum who would be hardly

hit, and rightly so, in his opinion.
Dr. Kirkpatrick, in reply, said he did not think the privilege of administering gas should be taken away from the dentists without due cause being shown, and the onus of proof lay with those who wished to with-draw the privilege. That was a point which had been lost sight of in discussions on the subject.

### CORRESPONDENCE.

### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.
Paris, May 23rd, 1909. THE DEPOPULATION PROBLEM. PROF. COURMONT, of Lyons, has recently sounded a note of alarm on the subject of the depopulation in

France.

France.

Hitherto, he says, France held the first place amongst the European nations. Political changes and wars reversed the position. After the war of 1870 France fell behind Germany. Germany had 41 millions inhabitants, France 36, then came Austria-Hungary with 35, England with 31, Italy with 26. In 1907, or 38 years afterwards, France had fallen to the fifth rank in Europe. Russia leads; Germany has advanced to 61 millions (gain, 20 millions); Austria to 48 millions (gain, 13 millions); England to 44 millions (gain, 13 millions). The population of France rose to 39 millions (gain, 3 millions only), while Italy has gained in the same period 7 millions (26 to 33 millions). (26 to 33 millions).

The annual increase per 1,000 inhabitants for the above countries renders more clear the facts. During one decade (1896-1906) the increase for Germany was one decade (1896-1906) the increase for Germany was 15.2; Austria-Hungary, 13.2; England, 11.8; Italy, 10.8; France, 1.5. In other words, each year one thousand Germans became 1,015.2; a thousand Austrians became 1,013.2; a thousand English 1,011.8; a thousand Italians, 1,010.8; while a thousand French became but 1,000.5. It is easy to calculate consequently in how many years Germany will have twice the population of France, and in how many years Italy will have outstripped France. Will this state of things improve? According to Prof. Courmont it will become rather worse. it will become rather worse.

Not only is the French gain slight, but it is too often transformed into a deficit. In certain years during the last decade, the number of deaths exceeded that of births. Such a fact is without precedent in the world during periods of peace and in the absence of grave epidemics. If energetic measures are not taken this will become the rule in France, and slowly but surely the life of the nation will go out. With regard to the effective population of the 86 departments into which France is divided, more than the half (44) presented in 1905 a decrease in the population; five (North of France) showed an increase of 3,000 individuals, while the remainder were stationary.

A remedy to such a situation is imperative, and this remedy Prof. Courmont believes it possible to find in hygiene. The factors of a problem are intimately connected with the research of the cause, and in order to find a solution to this problem, each of the factors must be studied separately

of the factors must be studied separately.

In the question of depopulation, the causes may be limited to two: natality and mortality. A country becomes depopulated either because it produces few children or because it loses too many. The movement of the population is the result of a balance between the receipts (births) and expenses (deaths).

NATALITY. French natality is the lowest in Europe and in the whole world! In Germany it is 33, in Italy 31, in England 26, and only 19 in France. But in this respect it may be said that the number of births diminishes everywhere. Since 1870, it fell from 35 to 33 in Germany, from 36 to 37 in Italy, from 35 to 26 in England, and from 25 to 19 in France. It is even in England that the birth-rate has, proportionally the most diminished

ally, the most diminished.

The causes of this diminishing natality are regulated by laws well-known to economists: degree of civilisation, expense of living, multiplication of needs, education, etc. Such are the general causes against which there is but little hope of reaction. It is, however, an acknowledged fact that restriction of natality is voluntary: a country has the number of children it wishes for; it is not a question of race, morality, marriage, divorce, etc.; it is a social and economical question, difficult to solve.

MORTALITY.

The mortality for France is 20 per cent. like that of Italy. Certain countries as Russia and Austria-Hungary have a much higher mortality, but Germanv (48 per cent.), England (15 per cent.), and above all the Scandinavian countries have a much lower mortality. Prof. Courmont is convinced that better sanitary conditions similar to those existing in England and Germany would considerably lessen the mortality in France, and procure some 300,000 individuals per year for the country. Many diseases are avoidable if proper prophylactic measures are taken. In France the three great causes of mortality are: Infantile mortality, tuberculosis, and alcoholism. Nothing has been done against tuberculosis, yet 100,000 deaths might be prevented. Alcoholism and especially absinthism are consuming the very vitals Infant mortality in Norway is of the population. 69.4 per 1,000 children, while in France it is 150. Thus 64,480 infants are annually sacrificed. By way of conclusion Prof. Courmont says that if it is imperative that the public bodies should adopt measures of sanitary reform against the threatening danger, it is also necessary that the French mentality should undergo a transformation. In France it is considered the proper thing to cover hygiene and sanitary reformers with ridicule; and doctors are the first to disobey the law by not notifying contagious diseases. The slightest ennui is intolerable, altruism is but a meaningless word, and selfishness governs the unfortunate country.

In order to understand the painful situation, it is necessary to travel, and especially to visit the northern countries. There all is discipline, faith in progress, in science; the general interest is the great social law. As soon as a measure, no matter how vexatory, appears necessary for the common good, every one submits. Questions asked as to the difficulty of establishing compulsory vaccination, or notification of contagious maladies are not even understood. The answer is: "But since it is the law!" Happy country!

In France, the word Liberté written on the public monuments is not understood. Absolute liberty cannot exist, there are only liberties: liberty to believe, to think, to vote, to write, is certainly sacred; but no liberty should be claimed to injure the neighbour, to disobey the laws, to let insalubrious dwellings, to sell absinthe, to refuse vaccination, or notify contagious maladies. Such liberty should not be tolerated.

Social sanitation is not comptatible with absolute liberty, it exacts a very clear comprehension of responsibilities and duties towards our neighbour; it is altruistic.

### GERMANY.

Berlin, May 23rd, 1909.

TRANSPLANTATION OF THE KIDNEY. At the Medizinische Gesellschaft, Hr. Unger discussed this subject. He first mentioned the earlier attempts to transplant the kidney, which always failed, until Carril introduced his method, which consisted in this: that he removed both kidneys along with a portion of the aorta and vena cava, the ureters and the bladder from one animal and transplanted them into another. The speaker had repeated the experiment. He explained the method to the Society by the aid of drawings. The chief difficulty of the operation, which with practice could be performed in from 50 minutes to an hour, consisted in the suture of the vessels which were only small in the animals experimented on. He had performed the operation 70 times. At first most of the animals died during the first few days either from narcosis or from uraemia, but the results gradually became better. Hæmorrhage was observed gradually became better. Hæmorrhage was observed on two occasions; several died from peritonitis. One bitch which survived the operation 18 days was not uræmic, but died of diarrhea; on examination after death a thrombus was found in the vena cava below the suture and an aneurysm at the site of the suture. A cat retained her own kidneys in addition to the transplanted ones, and lived four weeks; when her own proper kidneys were then extirpated she died of uræmia. In many similar cases it was seen that when the proper kidneys were at first left in, the microscopical changes in the transplanted kidneys were greater than when they were extirpated at once.

The speaker concluded that the experiments showed that kidneys removed from one animal and implanted into another continued to act, and that the disturbance of the circulation caused by the operation gradually

Hr. Benda had examined several of the kidneys removed, and found in them infarcts and hæmorrhages, but the tissues were undoubtedly well retained, both in the glomeruli and in the canaliculi.

Hr. Katzenstein made a report on experiments he

Hr. Katzenstein made a report on experiments he had made regarding the establishment of a collateral circulation in the kidneys.

He displaced the kidney outwardly, so as to stretch the renal artery and narrow its calibre, and thereby make the circulation more difficult. This was necessary, as the blood always went the nearest way, and the development of collaterals did not take place. He then fixed the kidney between the abdominal muscles, and six weeks later divided the renal artery. The kidney now acted smoothly, and the injection passed from the aorta, in spite of the ligature of the renal artery.

artery.

Hr. Zondek said he had performed similar experiments, but without success.

At the meeting of May 5th, Hr. Hartog related a case of

PUERPERAL PYÆMIA WITH RECOVERY AFTER TREN-DELENBURG'S OPERATION.

A woman aborted at the sixth month of pregnancy with symptoms of high fever. The fever continued after the abortion, with fætid discharges from the vagina, and numerous injections of Aronsonn's serum had not dissipated it. The speaker saw the patient a month after the abortion. There were then rigors, a pulse of 120 to 130, the temperature rose to 40° C., and the general condition was bad. Considering that the case was one of undoubted pyæmia, he proposed Trendelenburg's operation, which, after some hesitation, the patient agreed to. At the laparotomy the broad ligament was found to be occupied by large

thick veins; double ligature of the hypogastric veins of both sides, ligature of the spermatic vein. The success of the operation was surprising; the next day the temperature had fallen to 38° C., and after that did not go above 37° C. After a favourable re-convalescence, the patient got up three and a half weeks after the operation, and continued her occupation as a midwife. The danger of the operative proceeding was but slight. A fatal termination followed on advance of the thrombus to the vena cava; operation, therefore, should not be too long delayed.

# AUSTRIA. Vienna, May 23rd, 1909.

At the "Gesellschaft der Aerzte," Nobl showed a patient, æt. 67, with a papular eruption on the arms, axilla, dorsum of penis, scrotum and lower limbs, ranging in size from a needle point to a hemp seed. They had a polygonal shape, a mother-of-pearl shimmer, steel blue colour with an erythematous base slightly elevated and irregular in contour, but when met with aggregated they were more ovoid and serpiginous. Whatever may have been the cause, the dominant opinion was a mechanical origin. This wos more prominently demonstrated in the palms of the hands and fingers, where the papules appeared like large shot covered with a horny lamella having a violet shiny colour. These patches would cover the area of a five-shilling piece.

In support of the traumatic origin a similar appearance, though seldom associated with it, was present on the mucous membrane of the mouth; on the upper and lower lips, angles of the mouth, and below the tongue these changes were present. None of the so-called lichen genisis was present as far as toxico-dermia was concerned, but the mechanical irritative cause recognised by Pospelow was incontrovertibly present.

PASTEUR'S DISEASE.

Beer, at the "Gesellschaft für Innere Medizin," raised the question of a new disease which was similar to many of the other subcutaneous changes, but of a more intense nervous change, which has led to the term hysterical being applied. The pain is usually confined to a narrow area located in the fibrous tissue, and resisting all treatment. It is sometimes accompanied with peculiar streaks on the cutaneous surface of a roseate or violet hue, with vascular dilatation. This peculiar diseased centre lies deep, but, with careful probing, the exact spot can be determined. Hitherto this disease had had no name, but, occurring in young pople, and the female sex as a rule, it has been classed under the head of hysteria, which is certainly a misnomer. The male sex is not exempted from the disease associated with the vascular ectasia, as may be often seen along the ribs of the drinker, but we find it not infrequently in the total abstainer also, accompanied with great pain. The principal sites are the hip, shoulders, back and chest walls.

A second form of this fibrous tissue disease is found

A second form of this fibrous tissue disease is found with no visible cutaneous phenomena, narrowly circumscribed with neuralgic pain above the pubis. The pain is the guide to cicatrix-like firmness in the deep fibrous tissue in the fascia near the sheath of the rectus muscle. A deep retraction about the size of a pea or a "heller" may be found, very painful, but movable from side to side. This pain is often out of all proportion to the observed lesion, not uncommonly associated with colic pains, which leads the attendant to the suspicion of gall-stone, peritoneal strangulation, etc., or to the diagnosis of neurosis, neuralgia, or some pressure on an abdominal nerve.

Whatever may be the cause of this deformity in the fibrous tissue, it is capable of promoting general rigidity of the locomotor apparatus, which was described by Larey and Percy about the beginning of the last century as extending to all the joints of the body, even to an ankylosis of the jaws.

Pasteur, in London, 1896, seems to have isolated the disease in his description of a young woman with spinal rigidity and apparent ankylosis of the distal joints of the limbs, including the knees and the elbows.

This fixation was not due to any disease of the joints, but some periarticular changes in the soft tissues, which is more rare than the rigid form of the spinal cord. From the sclerodermic combination, the rigidity of the spinal cord is more frequent than the fixation form, which led Pierre Marie to affirm that it was a disease of the articulations of the spine and large joints. It is important to know that this rigidity of the spine, combined with shoulder and hip joints, have no disease to be recorded, but the periarticular soft parts have been found changed, but curable.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

### SCOTLAND.

THE LATE DR. W. W. IRELAND.—There passed away suddenly, on the 17th inst., at his home in Musselburgh, Dr. W. W. Ireland, well-known by his work on imbecility and mental defect. Dr. Ireland, who was in his 77th year, was a veteran of the Indian Mutiny. He was an assistant surgeon attached to the Bengal Horse Artillery, and received his baptism of fire at the siege of Delhi, where he was dangeroulsy wounded and lost an eye. After a long and tedious conva-lescence, he returned to Scotland, and devoted himself to the study of mental diseases. He was a man of unusual culture and breadth of mind, an accomplished linguist, and a scholar, as his numerous contributions to psychology and other paths on the borderland of medicine testify. He was a corresponding member of the Psychiatric Society of St. Petersburg, and of the Medico-Legal Society of New York, and was a diligent frequenter of various foreign and international psychiatric congresses. His principal work, "On Idiocy and Imbecility," appeared in 1877, and in 1898 a further volume, "The Mental Affections of Children: Idiocy, Imbecility, and Insanity," was published. Idiocy, Imbecility, and Insanity," was published. Until quite recent years Dr Ireland's work continued to be almost the only text-book in the English language on the product of the control of the contr guage on the particular subject, and though it now has authority. Among other well-known books, "The Blot on the Brain" (1885) and "Through the Ivory Gate" (1889), may be specially referred to. They are studies in heredity and psychology, and are illustrated with a great wealth of historical example. Dr. Ireland was at one time Medical Superintendent of the Larbert Institution for Imbeciles, and of Miss Mary Murray's Institution for Girls at Prestonpans. Dr. Ireland continued to take a keen interest in medical work until the last days of his life. Only a few years ago he read at the Edinburgh Medico-Chirurgical Society a paper on the alleged increase of insanity in Scotland, in which he concluded that the increase was largely a matter of statistics. He was a regular attender of the Morison lectures and other meetings connected with his speciality. In 1905, the jubilee of his entry into the medical profession, a number of his friends presented him with a purse of sovereigns, and it was characteristic of the man that he resolved to devote part of this money to the publication of an historical work on which he had for some time been engaged. Dr. Ireland was greatly and deservedly respected by those who knew him. He was a hospitable, kindly gentleman, a man of upright character and quite exceptional attain-ments. Dr. Ireland is survived by a son and daughter, the former being a member of his father's profession.

THE LATE DR. KENNEDY, EDINBURGH.—On the day of Dr. Ireland's death, a large circle of patients and friends were shocked by learning that Dr. Charles Kennedy expired with tragic suddenness. He appeared to be in his usual health on Sunday, and left the house shortly after midnight with the intention of visiting a patient, but only got a step or two from his front door when he died from sudden heart failure. Dr. Kennedy was about fifty years of age, and was a son of the late Mr. David Kennedy, the well-known Scottish vocalist, from whom he inherited many of the musical qualities which distinguished the family. He graduated M.B., C.M., in 1881, and four years later was awarded a gold medal for his M.D. thesis. He had a large

practice in Edinburgh, and was an enthusiastic Freemason. His vocal talents brought him much into request on all social occasions, and he was a popular member of the Pen and Pencil Club. He is survived by a widow and three children, one of whom is studying medicine.

PRINCIPALSHIP OF ABERDEEN UNIVERSITY .- Amongst other names spoken of in connection with the appointment of a successor to the late Principal Marshall Lang are those of Professor George Adam Smith (Glasgow), Professor Matthew Hay (Aberdeen), and Professor Sir W. Mitchell Ramsay. The appointment rests with the Crown. Local feeling appears to favour

the selection of Professor Matthew Hay.

EDINBURGH PARISH COUNCIL AND THE ROYAL INFIRMARY.—At a meeting of the Council held on May 17th, the question of the treatment of cases of temporary mental disease in the Royal Infirmary was under discussion. The sub-committee which has been dealing with the matter (which arises out of an application by the Infirmary for a contribution from the Council's funds), reported (1) that the poor of the parish receive such benefit from the Infirmary as warrants the Council's favourable consideration of the managers' application for a grant; (2) that a contribution of £150 a year be made; (3) that a payment of 3s. 6d. per diem be made to the Infirmary for each case of temporary mental disorder sent to that institution by the Inspector of Poor. The report was adopted tentatively for a period of one year.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH.-

ROYAL COLLEGE OF SURGEONS OF EDINBURGH.—
FELLOWSHIPS.—At a meeting of the College, held on
the 19th inst., the following gentlemen were elected
Fellows:—James Malcolm Christie, M.B., Ch.B., Edinburgh; John Gilmour, M.B., Ch.B., Edinburgh;
Ralph Tennyson Jupp, M.B., Ch.B., Ilford; Angus
Dugald Macintyre, M.D., C.M., Canada; John
Stevenson Mitchell, M.B., Ch.B., Dunfermline;
George Raffan, M.B., Ch.B., Edinburgh; Henry
Speirs, M.D., Gavinton, Duns; Cyril Hocken Tewsley,
M.B., Ch.B., Bradford; and Reginald William
Townley, L.R.C.S.E., Portobello.

AWARDS.—The bronze medal and microscope pre-

AWARDS.—The bronze medal and microscope presented to the Royal College of Surgeons, Edinburgh, by Colonel William Lorimer Bathgate, in memory of his late father, William McPhune Bathgate, F.R.C.S.E., Lecturer on Materia Medica in the Extra Academical School, was awarded, after the usual competitive written examination in Materia Medica, etc., held for the Session 1908-1909, to Miss Marion Macintyre, of Edinburgh; and the first annual award of the Ivison Macadam Memorial Prize in Chemistry. consisting of a bronze medal and case of instruments, was, after a competitive written examination in Chemistry, held for Session 1908-1909, made to Mr. Charles Henry Kemball, of Edinburgh.

# LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

MEDICAL LAW REFORM.

To the Editor of The Medical Press and Circular.

SIR,—In your Editorial Note to-day on the recent dental prosecutions, you remark that "the day of the quack dentist seems drawing to a close, and, like the unqualified medical assistant, he will probably disappear from the scene." It will be surely the fault of the profession if not only the unqualified assistant, but the unqualified and fraudulent pretender, does not also disappear from the scene. It is impossible to believe that reform could be delayed for a day if the Legislature was once made clearly to understand the present scandalous condition of medical law. has been done for dental and veterinary surgery can be done for the medical profession. The letter of "An Obscure Practitioner" puts the case admirably. The movement towards the appointment of a Royal Commission is, I am glad to say, advancing. The Council of the British Medical Association, and the General Medical Council, have both taken the matter up, and it has been brought before the Privy Council. Out of

this has arisen action by the Local Government Board. The Board has issued a circular to Medical Officers of Health asking for information with regard to unqualified practice in their districts. Unfortunately the several Councils have not included the traffic in quack medicines and apparatus within the scope of the promedicines and apparatus within the scope of the proposed Commission. Great part of fraudulent practice is carried on under the cloak of that traffic, and if this be not included in the inquiry, any legislation based upon the Commission must prove largely futile. I am striving to draw attention to this fact. I hope you may feel disposed to help me

I am, Sir, yours truly, HENRY SEWILL

May 19th, 1909.

# THE CAMPAIGN AGAINST UNQUALIFIED DENTISTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—It is to be hoped, now that some of the unqualified dentists have been convicted and fined, that the campaign will extend to all unqualified pretenders the capacity of -- the cancer curer, the bone setter, etc., etc. gentry cannot even put forward the excuse the make-believe dentists can—viz., "living from hand to mouth," and if the heavy fines inflicted have been paid, it would go far to disprove the excuse, but will probably make all offenders look "down in the mouth in future. Without attempting to excuse unqualified dentistry, I may say I have seen better work in the way of dentures produced and fitted by such, when three times the amount had been paid previously by waters to qualified dentists, who, on finding no comfort, sought with success the services of the unqualified man. I feel sure I can be supported in this statement by other medical men, and the question may be asked: Who really does most of the work for the curlified dentist? qualified dentist?

I am, Sir, yours truly,

ALEXANDER DUKE.

# THE MEDICAL LIBRARY ASSOCIATION. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir,-In connection with the first meeting of the Medical Library Association, to be held in Queen's College, Belfast, during the last week in July, a loan exhibition will be held illustrating medical libraries and medical literature. Amongst other things, we are and medical literature. Amongst other things, we ever particularly anxious to receive the following:—(1) MSS, and early printed books. (2) First editions of noteworthy books. (3) Early Irish printed books (there are few, if any, before 1700). (4) Books on tuberculosis. (5) Books upon Celtic medicine. (6) Photographs of libraries. (7) Statistical diagrams giving number of volumes issues readers income atc giving number of volumes, issues, readers, income, etc. (8) Library papers, rules, etc.
The Association will insure all loans, and the

exhibits will be most carefully guarded.

We venture to hope for early and favourable replies, as the time for the preparation of the exhibit is rather short.

We are, Sir, yours truly J. WALKER HALL, CUTHBERT E. A. CLAYTON, The University, Manchester, May 19th, 1909.

# LOCAL GOVERNMENT REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir,-On more than one occasion, when writing in your valuable paper on the question of sanitary administration, and the positions of medical officers under the Poor-law and under Public Health Acts, I have pointed out that mal-administration and neglect of necessary laws in both departments are mainly due to the inferiority of the local authorities. These authorities are in most places largely composed of, or dominated by, ignorant and vulgar men, who when they have the capacity to understand the importance of their duties, too often allow the furtherance of their own sordid interests to stand in the way of performance of them. This state of things is (as I have also

explained) due to the apathy of responsible classes of the public who decline to take any interest or part in local affairs. The intellectually better part of cracy shirks its duty. I have often urged that local government might be made more efficient in every way if the machinery were largely converted into a bureaucracy. In this the example of Germany might be followed The public should have the assurance, as they have in Germany, that the Government were acting nave in Germany, that the Government were acting upon the best scientific advice, and the orders of the central body might then be carried out. It is interesting to note that Mr. John Burns, in a speech on May 15th, takes up a similar position. Speaking of the need for speedy action in the matter of Poor-law reform, Mr. Burns argued that the best way would be to give a free hand to the President of the Local Government Board, only stipulating that he should report on what he had done every three months to Parliament, so that sanction should be given for each instalment of administrative reorganisation. Mr. Burns is a Radical of Radicals, a Democrat of Democrats, and yet he suggests it as his conviction that it is in some directions less beneficial for the people to govern themselves than to entrust their interests to the control of a well-advised Government department. Most medical officials who have had sufficient experience of our present democratic system will, I think, feel disposed to agree with Mr. Burns.

I am, Sir, yours truly,

M. O. H.

May 17th, 1909.

# AMERICAN BAKED BEANS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-In your "Notices to Correspondents" last week, mention was made of haricot beans, and American baked beans were mentioned as a wholesome and palatable article of diet. Until a few years ago, American "canned" beans could be got without being wired with the state of the sta mixed with tomatoes, but of late this has not been possible, at any rate as regards myself. Not being able to get them in their unmixed state, I was glad when a lady resident in America, on a visit to this country, instructed me in the American way of cooking beans. The method is as follows:—Allow a pint of beans to simmer three hours, then pour off the water, and place in a baking pan along with a small piece of salt pork or mild-cured bacon, and place on top a good dessertspoonful of syrup, put in just enough water to cover all. Bake until the top part is brown, then stir all up thoroughly, and put back into the oven, until the top is again brown; stir up again. and put into the oven again, continuing this until the whole is a uniform brown throughout. The beans are then ready for serving. With fried ham or any white meat they are a really palatable form of vegetable. Even when cold they are very good to form the substantial part of a salad.

I am, Sir, yours truly,

I. E. B.

# THE VIRULENCE OF INFECTIOUS DISEASE. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir,-The April number of Janus contains an article to which I should like to call the attention of physicians and historians. I offer no comment on the views put forward, but as they may influence medical practice, as well as throw light upon history, medical men throughout the world would do well to consider

The writer, Dr. Otto Effertz, a Governmental vaccinator in Mexico, attempts to prove that the virulence of an infectious disease is not absolute, but relative, being the resultant of two factors, varying according to the country in which the disease is endemic and the to the country in which the disease is endemic and the people who are attacked by it. These factors are:—

(1) The virulence of the microbe, which differs in different countries; (2) the extent to which the patients have become immune through natural selection. In other words, the microbes, as the result of their struggle with men, gradually increase in strength; natural selection evolves more powerful microorganisms. On the other hand, a race of men is evolved more capable of resisting them. The resultant

represents the malignity of the disease, and it will vary as the factors vary. Dr. Effertz then notices two remarkable facts:-(1) African malaria is deadly for Europeans, but very mild for Africans. (2)
American malaria is deadly for American Indians,
but mild for Europeans. He infers (a) that
the African parasite has grown more virulent
during the thousands of years it has been in Africa; (b) that the American parasite is much less virulent, having been recently carried to America. The African negro has won his battle; the European has partly won it; the American Indian has yet to win it. The European is superior to the American parasite, but inferior to the African parasite. The Indian is inferior, the African negro superior, to both.

Dr. Effertz applies similar reasoning to syphilis and yellow fever. He shows that the Spaniards could not have carried out their conquests if the Continent had been as fever-stricken as it is now, and as a matter of fact history tells us little about fever in those days. Malaria was probably brought over from Europe; it now kills over 50 per cent. of all Mexican Indians.

America, by way of return, gave syphilis to Europe.

I am, Sir, yours truly,

W. H. S. Jones.

[We insert our correspondent's interesting letter in the hope that it may bring forth some comment from those who have had special experience of the subject. -ED. M. P. AND C.1

# OBITUARY.

PERCY BOULTON, M.D.EDIN., WE regret to announce the death, after a long ill-

Seymour Street, W., in his 68th year.

Dr. Boulton was educated at Beverley Grammar School and at Edinburgh University, where he took the degree of M.D. In 1863 he began practice at Western and two westerns are to London Worksop, and two years later he came to London. For 30 years he was a physician to the Samaritan Free Hospital, and afterwards he was elected consulting physician. He had also been a physician to Queen Charlotte's Hospital, and was a cophysician to the British Home for Incurables. consulting

Dr. Boulton devoted much of his time in later life to the question of the compulsory registration of mid-wives, and he took an active part in the passing of the Midwives Bill in 1902. For nine years he was a member of the Obstetrical Society's board for the examination of midwives, and for four years he was

# SIMEON HOLGATE OWEN, M.D., R.U.I., M.R.C.P.

WE regret to record the death of Dr. Simeon Holgate Owen, which occurred on May 19th. Dr. Owen was one of the best known physicians in Manchester. The son of the late Mr. Henry Owen, dental surgeon, he was born sixty-five years ago, and took his degree in 1872 at the Royal University of Ireland. Dr. Owen was always in close touch with the various medical institutions of the city. He was President of the Manchester Clinical Society, Consulting Physician to the Manchester Northern Hospital for Women and Children, and Assistant Physician to the Infirmary, while before its incorporation he was also the Medical Officer for Moss Side. Dr. Owen lectured several times before the Sanitary Association, and, apart from various medical articles, he wrote much on literary

# SPECIAL ARTICLES.

# THE TWELFTH INTERNATIONAL CONGRESS ON ALCOHOLISM, London, 18th to 24th Ju'y, 1909.

THE object of this Congress, of which H.R.H. the Duke of Connaught is Honorary President, and the Right Hon. Lord Weardale Acting-President, is to consider the Causation, Prevention and Cure of Alcoholism, from both their individual and national aspects, in the light of research and experience afforded by the universal interest in the problem of Inebriety which prevails throughout the world. The arrangements for the Congress are now in a forward state, and a considerable number of members has been enrolled representing the Temperance forces of all degrees in nearly every European country, as well as in the United States, India, and our Colonies.

His Majesty's Government are taking considerable

interest in the Congress, and are giving the official reception at the Imperial Institute on the opening night, when the First Commissioner of H.M. Works, the Right Hon. Lewis Harcourt, M.P., will receive the members, and the Representatives of Foreign and Colonial Governments who have appointed delegates on the invitation of our own Foreign, Indian, and Colonial Ministers.

The proceedings will commence on Sunday, July 18th, with the official sermon, to be preached by the Right Rev. Bishop of Croydon at the afternoon service in St. Paul's Cathedral. The headquarters of the Congress will be the Imperial Institute, South Kensington. The Congress sittings will take place in the Kensington Town Hall, in the Conference Room at the Imperial Institute, and in the Theatre of the Victoria and Albert Museum close by.

The first general meeting on the Monday morning

will be devoted to the Inaugural Address of welcome by the Acting-President, Lord Weardale, and to brief speeches in response from Governmental and Tempespeeches in response from Governmental and Temperance representatives of foreign countries and the Colonies. This will be followed in the afternoon by the formal opening of the Exhibition by the Very Rev. the Hon. Dean of Hereford, Chairman of the Conveners, and in the evening by the Grand Official Reception. During the week there will be many other social engagements to interest sections of the membership; these will include, as already arranged, a reception of medical members by the British Medical Temperance Association at the London Temperance Hospital; breakfasts by several important committees; and a Masonic reception by the London Temperance

The scientific side of the International Congress has always received a considerable share of attention, and on this occasion a series of sectional meetings on the Tuesday, Wednesday, and Friday of Congress week has been allotted to it. Among the distinguished foreign members who will contribute papers are: Professor Taav. Laitinen, M.D., Helsingfors, who, in addition to his "Norman Kerr Lecture," under the auspices of the Society for the Study of Inebriety, on "The Influence of Alcohol on Immunity," will make "A Further Contribution to the Study of the Influence of Alcohol on the Degeneration of Human Offspring" in continuation of his remarkable deliverance at Stockholm in 1907. Dr. A. Holitscher, Carlsbad, will report on "Alcohol in Lobar Pneumonia and Enteric" and on "The Consumption of Alcohol in Hospitals and Asylums"; Dr. Legrain, Paris, will deal with "Alcohol and Insanity"; and Dr. Stein, of Budapest, with "Alcohol and the Nervous System."

The opportunity for foreign scientists to hear their

British confreres being but infrequent, the services of several well-known exponents of ascertained facts upon several well-known exponents of ascertained facts upon the alcohol question have been secured. Among the subjects to be treated by them are: "Alcohol and Temperance," by Professor G. Sims Woodhead, M.D., F.R.S.Ed., Cambridge; "The Action of Alcohol on Muscular and Mental Fatigue," by Dr. W. H. R. Rivers, F.R.S., Cambridge; "The Resistive Power of the Brain Against Alcohol," by Professor Clouston, M.D., Edinburgh; "The Effects of Alcohol on the Nervous System as Exhilibred in Hospital and Asylum Practice," by Dr. F. W. Mott, F.R.S., London.

The economic aspect of the problem of alcoholism

The economic aspect of the problem of alcoholism will be considered at the fourth general meeting on the Thursday morning, at which an important contribution will be made by the Right Hon. Sir Thomas P. Whittaker, M.P., on "The Economic Effects of the Production and Consumption of Alcohol." The discussion upon this will be followed by two papers on cognate subjects, viz.: "The Alcohol Problem in the Light of Vital Statistics," by Herr Hansen of Kiel; and "Alcoholism and Industrial Assurance against Disaster and Invalidity," by Herr Karl Kögler, of Vienna. Considerable interest attaches to these papers as their topic is engaging the attention of many social reformers in this country; a number of German, Austrian and Hungarian members have expressed a desire to speak, and it is evident that some valuable information from official sources will be given to the Congress.

The Treatment of the Disease of Alcoholism on its preventive as well as its remedial side will engage the attention of the Congress on the last two days. The legislative aspect will be presented by Alderman F. S. Spence, of Toronto, and Professor Jensen, of Bergen, who will deal respectively with the "No Licence" and the "Management" methods; while the International Question in regard to "Native Races" will be dealt with by Herr Vietor, of Bremen. These subjects will occupy the fifth general meeting and an afternoon session on the Friday; and on the Saturday at the sixth general meeting the "Conclusion of the whole matter," from what may be called the Home Office point of view, will be presented. "Alcoholism and Crime," by Lieut. Colonel A. B. McHardy, Edinburgh, Chairman of the Prison Commissioners for Scotland; "Treatment of the Criminal Inebriate," by Professor G. Aschaffenburg, of Cologne, and "Legislation for the Inebriate," by Dr. R. W. Branthwaite, H.M. Inspector under the Inebriate Acts, are the names of papers and readers.

There will, of course be public demonstrations during Congress week; there will be at least one of great interest, which will take place on the evening of Wednesday, July 21st, in the Queen's Hall, under the presidency of the Right Hon. Lord Alverstone, Lord Chief Justice of England. Full information will be published in good time, meanwhile application for membership should be made to the Honorary Registrar, care of the National Temperance League, Paternoster House, London, E.C. The subscription is 10s.; a contribution of half that sum entitles an "Associate" to receive a copy of the Congress report and cards for the public engagements only. Donations to the necessarily heavy expenses will be duly acknowledged by Mr. J. S. Higham, M.P., Chairman of the Finance Committee, if sent to him at 14 St. James's Court, Buckingham Gate, S.W.

# MILITARY & NAVAL MEDICAL NOTES.

A QUESTION has been raised owing to the exchanges allowed between officers of the Royal Army Medical Corps and the Indian Medical Service. The War Office has recently sanctioned an exchange between Captain H. P. G. Easton, I.M.S., and Captain H. G. S. Webb, R.A.M.C. What is to be the relative position, asks the *Pioneer Mail*, in respect of Service standing which these officers will hold in the respective spheres to which they have been transferred, assuming that the date of their first appointment and of their present rank is not identical, and that upon admission to the Service each of them did not occupy a position identical in order of merit with their contemporaries immediately above and below each of them respectively?

A GOOD, wholesome order has been issued to prevent young bandsmen and the like in the Army from smoking. It is directed that no tobacco, cigars, cigarettes, or smoking material of any kind are to be sold or supplied in regimental institutes to any person under the age of 16 years, and no such person is to be allowed to smoke in any part of the institute. Some control even over the strength of the tobaccos sold in regimental canteens or institutes to soldiers might, we think, result in good.

A PRETTY good lesson has been imparted to a Private Alexander of the Gloucester Regiment in Bombay.

This soldier with two companions went to the Victoria Gardens and began to indulge in the insensate and dangerous habit of teasing a lion with a stick, when the beast seized him with its paws dragging him against the bars of the cage. Private Alexander received severe injuries to his right arm and a number of wounds on various parts of his body before he could be freed from the clutches of the infuriated beast. He was rescued with difficulty, and was in hospital, where he will have ample time to reflect.

WE have already twice alluded to the correspondence in the Naval and Military Record on "Nursing in Naval Hospitals." In the issue of that paper on the 13th inst. a "Matron of Long Experience" in a Civil Hospital expresses in a letter her surprise at the existing duty arrangements in Naval Hospitals. If there are grave defects, how is it no Member of Parliament has been asked to interrogate the First Lord of the Admiralty?

NON-DIETED observation hospitals have now been opened at Bulford, Darrington and Rollestone Camps, under arrangements made by the Royal Army Medical Corps at Tidworth for the Regular troops now under canvas at these centres.

MAJOR F. W. CORNWALL, I.M.S., Director of the Pasteur Institute, has left Coonoor, in the Neilgherries, for Australia, having teen medically advised to take a sea voyage. Major R. Bryson, I.M.S., Medical Officer at Coonoor, officiates as Director.

THERE has been a great commotion over the promotion of Colonel C. B. Lukes, I.M.S., to be successor to Surgeon-General Bomford as Director-General of the Indian Medical Service. This officer has been indeed favoured, having passed over the heads of several of his seniors in the I.M.S. The only parallel to this rapid advancement was, some years ago, the promotion of the present Director-General Army Medical Service.

# REVIEWS OF BOOKS.

ROSE AND CARLESS' SURGERY. (a)

WE well remember the favourable reception this Manual of Surgery by Rose and Carless received when it was first published in 1898. In a very short time it seemed to be generally recognised as the book for students on the subject. It has now reached its seventh edition, and no greater proof of its deserved popularity can be mentioned, than that it has been found necessary to re-edit, or reprint it each year, with the exception of 1003, since it first appeared.

with the exception of 1903, since it first appeared. Rose and Carless' Surgery is so well known now by the profession, that a detailed account of the text, illustrations, and general get up of the work, is hardly necessary. However, for the benefit of those who may not be already acquainted with this manual, we may say that it not only contains all that is necessary for any pass examination in surgery, but that it is a work that can be consulted later with the assurance that one will obtain all such information as is likely to be of practical use in considering the diagnosis and treatment of cases. The first chapter deals with Surgical Bacteriology, Infection, Immunity, and constitutes a very fitting introduction to the succeeding chapters, which are devoted to Inflammation, Gangrene, etc. The chapter on the general technique of operative surgery requires special notice, on account of its practical utility and completeness. In this connection it is convenient to draw attention to the ex-

<sup>(</sup>a) "A Manual of Surgery for Students and Practitioners." By William Rose, M.B., B.S.Lond. F.R.C.S., Emeritus Professor of Surgery and Member of Council, King's College, London, and formerly Senior Surgeon to King's College Hospital, etc., and Albert Carless, M.S.Lond., F.R.C.S., Professor of Surgery in King's College, and Surgeon to King's College, Hospital, London, Examiner in Surgery to the University of London and to the Viotoria University of Manchester, etc. Seventh Edition. University Series. London: Bailliere, Tindall and Cox. Price 21s.

cellent descriptions, accompanied by the necessary anatomical details, of special operations, which will be found throughout the book. The next chapters discuss the diseases and injuries of various tissues. It is a decided recommendation in a book of this kind to have one subject treated and dismissed in one chapter, or in two consecutive chapters, as the case may be, and not scattered through a work, as we often find it elsewhere. For instance, Chapter XIII. gives a complete account of the surgery of veins, and Chapters XXIII. and XXIV. of injuries of the spine and diseases of the spine. The descriptive power of the authors is perhaps best shown in their discussion of abdominal surgery. One cannot fail to be impressed with the graphic account of intestinal obstruction, and of the various surgical conditions of the kidney. Chapter XLIII. on amputations is a more exhaustive treatise on the subject than is usually found in a general surgery. All the more common operations are given in detail. The last chapter gives an account of local, spinal and general anæsthesia. The book contains a very full index for reference, occupying pages 1329 to 1376, inclusive. The seventh edition has several new illustrations, mostly dealing with the X-ray appearances of fractures, and photo-micrographs of the histology of tumours. Also fresh material has been added, especially in connection with bacterial vaccines and opsonins.

On account of the consecutive arrangement of the subject matter, and the lucid style in which this book is written, Rose and Carless' Surgery is a particularly easy one to study, and from which to acquire a really sound knowledge of the principles which underlie modern surgery, and of the significance of clinical observations. The practitioner will find here a concise and thoroughly practical description of surgical conditions and their most effective treatment. We can therefore confidently recommend this manual of surgery both to the practitioner and student. It is well printed, judiciously illustrated, is convenient in size, and is altogether the most satisfactory book of its kind on the subject before the profession. We heartily congratulate the authors and the publishers on their excellent work.

# THE NAUHEIM TREATMENT OF DISEASES OF THE HEART AND CIRCULATION. (a)

That this little book is popular—and, we think, deservedly so—is shown by the fact that already a third edition has been found necessary since it was first published in 1904. In it the author explains clearly and in detail the manner in which the Nauheim treatment may be successfully employed at home, thus increasing its sphere of usefulness and bringing it within the power not only of those who cannot afford to go to the spa, but also of those who require its aid during the time when Nauheim is not available. There is, of course, much difference of opinion as to the value of this method of treatment, but we note that the author does not claim for it the unreasonable position in which many of its more fanatic supporters would place it.

The resistance movements, so difficult to understand from any written description, are rendered very obvious and easy by a series of good illustrations. confess that the last chapter, which contains the records of cases successfully treated, does not seem to us to favour the author's contention, for some of the diagrams which illustrate the reduction of the cardiac dulness, appear to show that the heart's dimensions after treatment are much smaller than normal. Yet cardiac atrophy, if it could be induced, would scarcely be beneficial. Again, in Case No. 4, that of a patient said to be the subject of aortic stenosis and mitral regurgitation, we should have thought that the presence of the apex beat within the nipple line after treatment, and the pulse tracing given, which shows a sharp apex and a distinct dicrotic notch, would of themselves refute the diagnosis. The book is well bound and printed, and fills a long-felt want.

### ORGANIC MATERIA MEDICA. (a)

THE last edition of this work has been out of print for some time, and in the present issue the opportunity has been taken of bringing it thoroughly up-to-date, especially those parts relating to chemistry and the physical and other characters of the drugs mentioned. Those characters which are common to each group are carefully described by way of introduction to the various groups, such as roots, barks, leaves, volatile oils, resins, etc. The volume deals not only with official remedies, but also with many which are not included in the British Pharmacopæia. Under each crude drug we find notes regarding its official characteristics, habitat, chemistry, uses, and preparations. The classification adopted is not the purely botanical one, but drugs of analogous form and physical character have been grouped together. In the present edition the work has been greatly improved and considerably extended, and doubtless it will continue to be the standard handy reference volume on its subject, as its predecessors have been. The work of revision has been thoroughly and effectively carried out, so that it comes as near perfection and completeness as one can expect in a book which covers so much ground within the compass of less than 400 pages.

#### DISEASES OF THE HEART. (b)

As might be expected by anyone who has followed Dr. Mackenzie's writings on cardiac disease as they have from time to time appeared in the medical journals, his book on diseases of the heart approaches the subject from a different standpoint to that of the older treatises. Discarding the plan of taking up each lesion separately and analysing the signs and symptoms to which it gives rise, he adopts the method of describing the symptoms of heart disease as they present themselves to patient and physician. The result is one of the most noteworthy contributions to the science of medicine that has fallen from the pen of any English writer for many years; and those who now for the first time become acquainted with Dr. Mackenzie's work will not fail to appreciate how great has been the advance in our knowledge of cardiac pathology during late years—an advance for which he, more than perhaps any other student of the subject, is materially responsible.

The book opens with chapters giving a good summary of modern teaching on the physiology and anatomy of the heart, and then proceeds to the discussion of subjective symptoms. Under this category comes pain, and in the chapter on angina pectoris Dr. Mackenzie offers good reasons for believing that the immediate factor in producing the attacks is exhaustion of the function of contractility of the heart. In connection with this subject the question of visceral pain generally is considered. Instrumental methods of examination are fully described; in particular the polygraphs invented by the author. Hæmometric methods do not rank high in his estimation. Much space is devoted to the interpretation of graphic tracings, and Dr. Mackenzie must be most cordially congratulated on the clarity of his exposition of what is really no easy subject to follow. This part of the book is unquestionably hard reading, but well repays the close study it requires. The difficulties are inherent, and even Dr. Mackenzie's lucidity does not banish them all. We next come to what are undoubtedly the most important and fascinating chapters in the book-those on cardiac irregularity. The modern classification into five main varieties is followed—sinus irregularity, extra-systole, nodal rhythm, defect of conductivity, and depression of contract lity. This is the same as Hering's grouping, though the nomenclature differs. It is not too much to say that a knowledge of the meaning of these irregularities is indispensable to intelligent treatment, and that their recognition constitutes almost as great an advance in the

<sup>(</sup>a) "The Nauheim Treatment of Diseases of the Heart and Circulation." By Leslie Thorne Thorne, M.D., B.S. Third Edition. Pp. 94, with 58 illustrations. London: Bailliere, Tindall and Cox. Price, 3s. 6d.

<sup>(</sup>a) "Southall's Organic Materia Medica." By John Barclay, B.Sc. Lond., F.C.S. Seventh Edition. Revised and enlarged by Ernest W. Mann, Pharmaceutical Chemist, sometime External Examiner in Materia Medica and Pharmacy to the University of Birmingham. London: J. and A. Churchill. 1909.

(b) "Diseases of the Heart." By James Mackenzie, M.D., M.B.C.P. London: Henry Frowde and Hodder and Stoughton. 1908.

study of heart disease as did the introduction of the stethoscope in the diagnosis of bruits. The later chapters of the book deal with arterio-sclerosis, valvular defects, congenital heart disease, heart disease in

pregnancy, and other subjects.

It is impossible to withhold a word of admiration for the enormous mass of observations this book represents, and it is little short of marvellous that they should have been made by one engaged in arduous general practice. But while this is so, the book could never have been written by a man whose experience was limited to hospital and consulting work. apparent throughout, particularly in Dr. Mackenzie's estimates of prognosis. He was able to watch his cases, not for months, but for years at a time, and has arrived at a judgment as to the gravity or otherwise of various signs and symptoms which differs somewhat from current teaching. The paragraphs on treatment are short, but to the point. They are, perhaps, open to the criticism of being as often destructive as constructive, but it is necessary to pull down before one can build up, and no doubt Dr. Mackenzie will some day remedy the defect. His remarks on Nauheim baths and the like are outspoken in the extreme; they ought to do some good in checking the exploitation and uncritical employment of these and other equally vaunted lines of treatment.

# LITERARY NOTES.

"NEW AND NON-OFFICIAL REMEDIES" is the title of a small book, descriptive of those drugs which have been accepted by the Council of the American Medical Association on Pharmacy and Chemistry prior to January 1st, 1909. The acceptance of the preparations included in this book has been based in part on evidence supplied by the manufacturer, and in part on investigations made by the Council. This volume is to be issued annually in future. Each article is followed by a brief description of its physical and chemical characters, its actions, uses, and dosage, together with the name of its manufacturer. There are many drugs, not included in the B.P. or U.S.P., which are of great value in medicine. These are all mentioned here. Thus we find our old friends ichthyol, heroin, sublamin, styptol, etc., which are often for-gotten or even unheard of by practitioners in this country. We trust this handy volume will tend to popularise many of the really valuable drugs recently introduced, but too little known as yet by the general

"THE CHILDREN'S CHARTER" is the title of a handy statement of the Children Act. It is written by M. K. Inglis, and published by Messrs. Thomas Nelson and Sons, at 6d. net. It is specially intended as a guide for social workers, and, as such, will doubtless prove of considerable value.

FROM Messrs. Bale, Sons and Danielsson comes an interesting little book entitled "Notes and Thoughts from Practice," by Dr. W. J. Tyson, of Folkestone. After many years of practice, the author gives us some of his own personal experiences of diseases and their ætiology, as well as their treatment. He strongly advocates greater clinical observation in these days, and maintains that hospital appointments ought to be paid. There is a great deal of common-sense in his remarks, and the book forms interesting and suggestive

WE have received the year book of the Universal Medical Esperanto Association (Tutmonda Esperanta Ruracista Asocio). It is well printed and illustrated with the most recent photograph of Dr. Zamenhof, the inventor of the language, it contains the report of the Hon. Secretary, Dr. Robin, of Warsaw, who states that he is thoroughly satisfied with the result of his suggestion made in La Vocho de Ruracistoj of June last, to found a medical association. The list of members shows that in the first 41 months there were

over 425, and we are informed that over 200 have since joined. From the list of consuls it would appear that practically every country in the world is already represented. Among the contents is the report of the International Committee of the Red Cross on the fourth (Dresden) Esperanto Congress, strongly recommending Esperants to all Red Cross Associations in the world, and giving an account of an interesting experiment carried out by Dr. Thalwitzer who, in ten lessons, succeeded in instructing a section of thirty men of the Saxony Red Cross, so that they could give and take orders, ask and answer questions in Esperanto, while giving a display of ambulance work. Generals Schmidt and Rühlemann (Germany), General Sebert (France), Major Straub (official delegate of U.S.A.), Dr. Kroita (Japan), Dr. Thalwitzer, and Dr. Zamenhof were present. The volume concludes with an article on Medical Terminology in Esperanto. Reference is also made to the Esperanto section which is being organised for the International Medical Congress at Budapest in August next.

# LABORATORY NOTES.

### GLIDINE AND IODOGLIDINE.

GLIDINE is a pure vegetable protein food, containing Lecithin, and practically free from carbohydrates. It is prepared from wheatmeal by a process combining centrifugalisation and a washing-out. The albumen thus isolated forms about 96 per cent. of the Glidine, the remainder being Lecithin and nutritive salts. As thus prepared Glidine is a fine yellowish-white powder, tasteless, and insoluble in cold water. It is claimed to be even more digestible than meat albumen, and to possess a facility of absorption, rendering it very suitable as a nutrient for convalescents from debilitating illnesses. It can be administered in a variety of vehicles: coffee, tea, cocoa, beer and milk. Emphasis is laid on its freedom from carbohydrates and "extractives.

In Iodoglidine, the iodine exists chemically combined with the wheat protein. Our analysis shows it to contain no free iodine and but a small amount of iodide in ordinary combination. It thus presents a marked advantage over the alkaline iodides. A minute amount of iodine is liberated in the stomach, the separation taking place almost entirely in the intestine. Some experiments we have made seem to show that the absorption of the iodine is slow and gradual, and we find the excretion of the iodine in the urine to be During the first twenty-four hours no very slow. iodine could be detected in the urine, a little was found during the second twenty-four hours, and, at the time of writing, which is during the third twenty-four hours after administration, an appreciable quantity of iodine is being excreted. These results confirm the elaborate experiments carried out by Continental workers, and seem to account for the fact that when iodine is administrated in this combination. when iodine is administered in this combination much less is required than when the alkaline iodides are used when the excretion of iodine begins a short time after ingestion and reaches its maximum in 24 hours. In addition, we gather that this Iodoglidine can be prescribed without fear of resulting "iodism."
We are favourably impressed with both of these preparations of Messrs. Menley and James, Limited.

# CAMPBELL'S CONDENSED SOUPS.

WE have examined tins of the mulligatawny and tomato soups as prepared by the Joseph Campbell Company. We find these soups to be free from boron preservatives and poisonous metals, and when prepared, to form appetising dishes. Some idea of the amount of concentration can be obtained from the fact that the tomato soup contains 14 per cent. and the mulligatawny 18 per cent, of dry solid matter. The flavour of these soups is excellent, and their preparation entails a minimum of trouble. The purchaser has a large selection of soups to choose from, and the manufacturers lay great stress on the searching cleanliness obtaining in the Campbell establishment. The English Agency for these soups is at 6-8 Bouverie Street, London, E.C.

#### SUMMARY RECENT MEDICAL LITERATURE, OF English and Foreign.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

The Pathology of the Red Degeneration of Uterine Myomata.—Lorraine Smith and Shaw (Journ. Obst. and Gyn. of the British Empire, XV., 4.) Based on the examination of five specimens, the first point investigated was the possible relation of the redness to the extravasation of blood either recent or of old standing. The sections gave no evidence of the presence. ing. The sections gave no evidence of the presence of recently extravasated red corpuscles so generally distributed as to explain the colour, nor was there evidence found of either hæmosiderin or free iron. Sections examined from the reddened areas and from areas which still remained of the ordinary colour were stained with Weigert's fibrin stain, and showed thrombosed vessels in the red areas, but none in the areas which were of normal colour. There was nothing found to contradict the hypothesis that the condition is associated with thrembosis throughout. The occurrence of thrombosis would lead to an increase in the size of the tumour, and this might explain the pain which was observed to accompany the increase in size. The authors consider pregnancy a probable predisposing factor in the causation of the condition, and that obstruction to the circulation might arise from pressure, or in the puerperium might be associated with the increase in coagulability of the blood which is said to occur. The tissue in which thrombosis takes place was not of the ordinary myomatous type in any of the specimens. The strands and bundles of muscle fibres were found to be in a condition of atrophy and degeneration, and had disappeared completely over considerable areas, their place being taken by a homogeneous substance which stains faintly with eosin, but otherwise presented no histological characters, this seemed to consist of the débris of the atrophied tissues, and was seen in the first instance in the neighbourhood of the blood vessels; frequently a blood vessel with a healthy wall was seen surrounded by an area of homogeneous material separating it from the muscular bundles which had not been attacked. In the tumours examined, where red colouration had occurred, this process of degeneration was present, and while it gave a general appearance of softening to the tumour the horse was represented and appearance of softening to the tumour them. change was never advanced and no definitely localised areas of softening were visible. Special attention was paid to the presence of fatty degeneration in the Special attention was paid to the presence of latty degeneration in the reddened tissues, and fat was found in considerable quantities in the breaking down fibres and wandering cells, and in cells round the thrombosed vessels, but the authors look upon the increase of fat not as indicative of increased activity in breaking down, but rather to an arrest in absorption. The authors conclude (1) that the change consists in thrombosis of the blood vessels. (2) This may commence at the periphery of the tumour. (3) The tumours are also in a state of degeneration. (4) The fat and fat crystals are probably derived from breaking up of muscle. (5) The tumours are liable to become infected and so cause toxic symptoms. (6) Pregnancy is probably a predisposing factor.

Hernias Through the Pelvic Floor.—Barrett (Amer. Journ. of Obst., LIX., 4). The author considers the embryological development of the pelvic diaphragm, and also points out the changes in the muscular arrangement of the lower animals and man, especially that of the levatores ani. He points out that some cases of prolapse where there has been no injury to the pelvic floor may be due to a reversion to the earlier type. He points out that hernia through the vaginal outlet is provided against by a strong posterior segment with a superimposed more movable anterior segment with the vagina running obliquely, so that forces from within press the anterior segment against the posterior. With the levator ani muscles injured

the anus and perineal body drop backward, leaving no support for the anterior segment which gradually gives way. Too often the efficiency of the perinæum has been considered to depend upon the cutaneous has been considered to depend upon the columneous structure, perineal body and mucous membrane, which are really of very minor importance, the perineal body only acting as a fixed point for the muscles to act upon. A traumatism of the pelvic floor may act upon. A traumatism of the pelvic floor may separate the preanal fibres of the levator ani, or may injure the anterior portion of the muscle or the muscle may be torn from its origin. These injuries may occur without tearing of the skin or mucous membrane and so be unnoticed, but they are the forms of tears which destroy the efficiency of the pelvic floor. The author gives the technique of a method for repairing the pelvic floor with a view to restoring the parts and enabling them to fulfil their function according to the authorizations he has pointed out. to the anatomical lines he has pointed out.

Amputation of the Uterus in the Corpus to Preserve the Menstrual Function.—Kelly (Amer. Journ. of Obst., LIX., 4). Having noticed that occasionally fibroid tumour cases, in which the ovaries had been left, but the uterine body had been removed with the tumours, would show a tendency to menstruate regularly for some months, and further that the patients were free from the marked discomforts of the artificial menopause, and were in better condition than those who had no menstruation. The author in selected cases proceeded on a plan of keeping a portion of the uterine body with the mucous membrane above the cervix in women who were still menstruating, and in this way succeeded in preserving regular menstruation in many cases. The two classes of patients best suited for this plan of treatment are those with fibroid uteri not suited for myomectomy, but not demanding panhysterectomy and those with subinvoluted hæmorrhagic uteri. It is sufficient to retain a little pocket of mucosa big enough to lodge the end of the little finger, or more if possible, with the corresponding muscular or more it possible, with the corresponding muscular tissue. The amputations are graded from those which are barely supra-cervical to those which are at the very fundus and are principally a myomectomy. The author has practised two styles, one horizontal and the other vertical. The amputation carried out by either of these methods leaves a little uterus which continues to menstruate moderately, and obviates the unpleasant sequelæ of the more radical operations. The author reports nine cases treated in this way with their after histories. their after histories.

A Preliminary Report on the Use of Bacterial Vaccines in the Treatment of Septic Infections.—Oastler (Amer. Journ. of Obst., LIX., 4). The report of five cases treated—four with success, and one not benefited the writer sums up as follows:-Apparently favourable clinical results have been obtained in the use of vaccines of streptococci, staphylococci, B. coli, B. mucosa and gonococci. All but gonococcus vaccine should be autogenous. Vaccines are not cure-alls, but seem to aid materially in combating the septic process. Vaccines are required where the blood shows poor resistance, i.e., low leucocyte count and high polymorphonuclear. In violent cases of acute sepsis no resistance can be created. The dose, site of injection and frequency was only problematic and experimental. Too large a dose does harm, small doses give better

A Case of Primary Sarcoma of the Vagina.—Maclean (Journ. of Obst. and Gyn. Brt. Emp., XV., 4). A girl of fifteen years of age complained of shooting pain in the left lower abdomen, dysuria, and the pressure of a soft mass at the ostium vaginæ. The

swelling had been noticed about one month. Protruding from the vagina was a dark red, soft, non-friable, papillomatous growth of the size of a tangerine orange; its surface like a cluster of currants. The attachment of the growth was about one inch broad, and extended from one inch posterior to the orifice of the urethra, to within one inch of the cervix on the anterior vaginal wall. The growth was removed and the base cauterised, but recurrence developed within six months. The stromal tissue appears mainly to be composed of a mass of cells with deeply staining nuclei and ill-formed blood vessels. The cells are both spindle and round, and of varying dimensions, some almost giant cells. The writer supplied a photograph of the tumour in situ, and two microphotographs of sections.

Comparative Rarity of Primary Carcinoma and Sarcoma of the Vagina.—Macnaughton-Jones (reprints). The writer points out that the total number of cases of undoubted primary carcinoma of the vagina has not yet reached two hundred. He gives the report of several interesting cases and the replies which he received in 1907 from several of the largest clinics in Germany. He quotes the clinical and histological facts pointed out by Williams:—(a) Vaginal irritation does not appear to play a part in its production. (b) Nearly all primary vaginal cancers appear to be of the squamous, epithelial, or epidermoidal type. (c) That vaginal cancer may be divided into tubular and lobular. (d) The posterior wall and upper part of the vagina is the most common site. (e) The most common period of occurrence is after the menopause. The Continental statistics collected give the frequency at under 2 per cent. of all cases of carcinoma of the female genitalia. The youngest cases on record appear to be Guersant's, aged 31 years; Johanowski, of years; and Smith's, 14 months. Cases are recorded where the wearing of a pessary seems to have produced the disease, as Maly's (Centrabl. f. Gyn., 1903), where a pessary was worn for 39 years, and the growth occurred in a furrow corresponding chactly to that of the ring. Petersen (Amer. Journ. Obst., 1903) recorded a case, aged 84 years. Primary sarcoma appears to be considerably rarer than carcinoma. The first case was reported in 1872, and up to 1899 only 32 cases were recorded, and from that up to 1904 only eight more were added. The record of non-recurrence after operation is low. Five are known to have been free from recurrence at periods of from 11 to 2} years after operation; two are stated to be free from recurrence, but the time is not stated; and two were of still relatively short periods; two the result is not known; two died at operation; three were not operated upon, and twenty-four recurred. The seat of the disease appears to be slightly if at more commonly the posterior than the anterior wall, and the age of patients generally under 40, a large number of cases being under 30, and cases are recorded in children 18 and 25 months of age. F.

Vaccines in Typhold.—Walters and Eaton (Boston Medical and Surgical Journal, April 22nd, 1909) publish information as to the results of the treatment of typhoid fever by vaccines of dead bacilli. They state that of 77 cases of typhoid treated in the Massachusetts Hospital in 1908, 31 were treated by vaccines, the remainder receiving only the regular routine of dietetic, hygienic, hydrotherapeutic, and drug measures in vogue. No selection of patients was made. In no case was anyone observed to be ill as the result of the vaccines, while the mortality among those thus treated was 3.2 per cent., as contrasted with a mortality of 11.1 per cent. among those not so treated. The authors give details of a few cases, but do not tell us the dose of vaccine employed.

# MEDICAL NEWS IN BRIEF.

An Unqualified Midwife.

AT Battersea, on the 20th inst., Mr. John Troutbeck conducted an inquiry with reference to the death of

a child named Charles James Albert Ellis, aged four weeks. The parents live at Battersea, where, it was stated, seven persons inhabited two rooms. The father of the child had been out of work for a long time. The mother stated that when she engaged a Mrs. Rollings as nurse she understood that she was certificated. Mrs. Rollings said her husband was a labourer, working for the Battersea Borough Council. She had no certificate and had never been trained, though she had done nursing for 36 years. In this case she used an ordinary pair of household scissors and afterwards noticed an abnormal appearance, but she did not call a doctor because she considered the parents had no money. She told Mrs. Ellis she had no certificate; she did not realise it was wrong for her to attend such cases. Medical evidence showed that death was due to blood poisoning, and that the septic condition might have been set up through the use of the scissors. The jury returned a verdict in accordance with the medical testimony, and held that Mrs. Rollings should be severely censured for having failed to advise the calling in of a doctor. The Coroner said he was informed that on a former occasion Mrs. Rollings had promised the County Council inspector that she would cease to attend cases. The condition of affairs was such that the Council might possibly think it their duty to take further action under the provisions of the Midwives Act.

# The Crusade against Bogus "Deutists" in Ireland.

DURING the past week a man named Byrne was prosecuted by the Secretary of the Irish Branch of the British Dental Association for infringement of the Dentists' Act, 1878. The infringement consisted in the terms of Byrne's advertisements, which, according to the summons, implied that the defendant was a person specially qualified to practice dentistry. After hearing the evidence, the magistrate imposed a fine of £5 on each of the two summonses, with 3 guiners costs

### The National University of Ireland.

THE Dublin Commissioners appointed under the Irish Universities Act, 1908, to make Statutes for the general government of the University have now done so, and the Statutes were issued to the Press on Friday last. They provide for the examinations and degrees of the University, and for the officers and the payment of officers of the constituent Colleges. So far as the medical schools of the Colleges are concerned, the professorships seem to be similar to those in other Universities. Perhaps the most striking part of the Statutes is that dealing with the teaching of Irish and other Celtic languages. In the three schools at Dublin, Cork and Galway something like £3,400 a year is to be spent in doing this, and according to the Freeman's Journal, in the case of the Dublin College, "over a tenth of the whole endowment of the College is assigned to its Irish departments."

# Society for the Relief of Widows and Orphans of Medical Mea

THE annual general meeting of the above Society was held at 11 Chandos Street, Cavendish Square, on Thursday, May 20th.

In the absence of the President, Mr. J. Warrington Haward, the Acting Treasurer took the chair. Twenty

members were present.

The Society's invested funds amount to £100,071, from which was derived in interest the sum of £3,121 17s. 1d.; £645 being received in subscriptions and donations.

During the past year the sum of £3,017 was distributed amongst the annuitants of the charity-namely, 48 widows and 16 orphans, each widow receiving on an average £50, besides an additional £10 as a Christmas gift, and each orphan £12 and a gift of £3 at Christmas.

The Copeland Fund is a special fund which enables

The Copeland Fund is a special fund which enables the Society to grant to any widow or orphan already in receipt of the Society's ordinary relief, extraordinary assistance in special circumstances of unusual distress, such as blindness, paralysis, insanity, severe disabling accident or grave permanent disease, and to continue such extra relief in the case of orphans beyond the age of sixteen or eighteen years (at which under the Society's existing by-laws, the ordinary relief ceases) for such further period as the Court of Directors may

During the year two widows in receipt of grants died. During the year two widows in receipt of grants died. One, whose husband had paid in subscriptions £19 19s., received £1,500, the other, whose husband had paid in annual subscriptions £31 10s., received £3,300; she had been in receipt of grants since 1855. Two new widows were elected during the year, and on December 31st there were 47 widows and 15 of phans in receipt of grants.

One of the widows has been on the books since 1854,

and has already received over £,2,200.

Relief is only granted to the widows and orphans of deceased members, who have paid their annual subscription for three years, or who are life members. During the year nearly fifty letters were received from widows of medical men, who, in many instances, had been left practically penniless, asking for relief, but this had to be refused, as their husbands had not been members of the Society.

The directors cannot too strongly urge upon the members of the medical profession, especially the younger, the desirability of joining the Society. Membership is open to any registered practitioner who at the time of his election is resident within a 20-mile radius from Charing Cross. Should any member 16move beyond the limits of the Society, he nevertheless continues to be a member.

The annual subscription is two guineas; every member who has paid this sum for twenty-five years becomes a member for life. Life membership may also be obtained by the payment of one sum, varying with the age of the applicant.

Further particulars and application forms may be obtained from the Secretary at the Offices of the Society, 11 Chandos Street, Cavendish Square, W.

A cordial vote of thanks was passed from the chair to the Editors of the medical papers who so kindly from time to time, publish notices of the Society.

# The Medical Graduates College and Polyclinic.

THE Medical Graduates College and Polyclinic held their ninth annual dinner, under the Presidency of Prof. Howard Marsh, on Monday, 24th inst., at the Trocadero Restaurant. About 130 ladies and gentlemen assembled to do honour to the function. After the usual loyal toasts by the Chairman, he gave "The Medical Graduates' College and Polyclinic," able responses being made by Sir Jonathan Hutchinson and Dr. C. Theodore Williams. Dr. C. O. Hawthorne next, in a sympathetic discourse, proposed the health of Captain A. E. Hayward Pinch, I.M.S., and presented that gentleman with a cheque in recognition of the eminent services he had rendered the institution during ten years. Captain Pinch said a few words in response and thanks. "The Guests" were proposed by Dr. Dundas Grant, and responded for by Sir William Church, and the entertainment was brought to a close by the few admirable and apposite words of Sir Donald MacAlister in proposing the health of the Chairman. Not the least enjoyable portion of the evening was the clever and artistic entertainment at the piano given by Mr. Harrison Hill.

### Pirst Inquest Under the Children Act.

An inquest, the first held in the Isle of Wight under the Children Act, 1908, was conducted at the Cowes Town Hall by the Acting Coroner, Mr. J. Eldridge, on Tuesday of last week. Under the provisions of this Act it is compulsory upon any person who nurses and maintains for reward one or more children under seven years of age apart from their parents to report to the Guardians within 48 hours of their reception all particulars concerning such children, and the death of a child had to be notified to the Coroner within 24 hours and to the Guardians within 48 hours. In regard to the child whose death was inquired into, no notification had been made by the responsible person, Elizabeth Moth. The deceased's name was Gladys Vaughan; she was an illegitimate child, and was 11 months old. Witness had had care of it for ten months. The child was very delicate from the

first. When she became ill she was taken to Dr. Scott, who prescribed for her. The next day the child who prescribed for her. The next day the child seemed better, but on Friday afternoon it had a fit and died. Witness had had as many as 15 children

and died. Witness had had as many as 15 children to nurse, but did not know that she should have reported the particulars to the Guardians.

Dr. H. F. N. Scott said when brought to him on Wednesday the child looked ill, but he did not think it would die so suddenly. By direction of the Coroner he had made a post-mortem examination, and found that the internal conditions were consistent with found that the internal conditions were consistent with the child having died of convulsions. The child was well nourished, and there were no external marks of violence. So far as he could see, the child had been looked after well, but, having seen the child but once, he did not think he should have been justified in

giving a death certificate.

The Coroner, in summing up, referred to the provisions of the Act already given, and said the Guardians had appointed a special officer to inspect the children and their homes, and if they were not satisfied with the conditions they had power to remove the children. In regard to the case before them, Mrs. Moth had given her evidence very clearly, but she did not know that she should have registered the child when she took it in and reported its death to the Coroner.

A verdict of "Death from natural causes" was

returned.

### Royal Navy-Successful Medical Candidates.

At the Entrance Examination for Surgeons in the Royal Navy, completed on the 14th inst., 32 candidates presented themselves for 15 vacancies. Two gentlemen withdrew, eight were rejected for physical

gentlemen withdrew, eight were rejected for physical defects, and, of the remaining 22, 18 obtained qualifying marks. The following is the list of successful candidates, arranged in the order of merit:—

K. H. Hole, M.B., B.S. Lond., L.R.C.P., M.R.C.S., Guy's Hosp.; G. F. Syms, L.R.C.P., M.R.C.S., Guy's Hosp., Birmingham; M. P. Fitzgerald, M.B., B.Ch., R.U.I., Queen's College, Cork; J. Hadwen, M.B., B.S., B.Sc. Lond., L.R.C.P., M.R.C.S., St. Bartholomew's; H. F. Briggs, M.B., Ch.B.Edin., Edinburgh Univ.; G. A. Jackson, M.B., B.Ch., B.A.O., Dublin Univ.; W. Miller, M.B., Ch.B.Edin., Edinburgh Univ.; J. S. Orwin, M.B., Ch.B.Edin., Edinburgh Univ.; J. Sarrett, M.B., Ch.B.Edin., Edinburgh Univ.; J. Barrett, M.B., B.Ch., B.A.O., R.U.I., Catholic Univ., Dublin; H. W. Nichols, L.R.C.P., M.R.C.S., Middlesex Hosp.; R. P. M. Roberts, L.R.C.P., M.R.C.S., Guy's Hosp.; M. G. Malcolm, M.B., Ch.B.St.And., St. Andrews Univ.; H. C. Devas, L.R.C.P., M.R.C.S., St. Thomas's Hosp.; H. Burns, M.B., Ch.B.Edin., Edinburgh Univ. The above-named gentlemen will undergo a course of instruction in special subjects at Haslar Hospital.

The above-named gentlemen will undergo a course of instruction in special subjects at Haslar Hospital. on the completion of which another examination will be held, and prizes consisting of a gold medal, a silver medal, and three Navy regulation pocket cases awarded. The final position on the list will be determined by the combined results of the London and Haslar examinations.

# Royal College of Surgeons in Ireland. Pellewship Examination.

THE following candidates passed the Primary part of the Examination:—R. H. Barter, F. C. Crossle, J. L. Lunham B.Ch., P. M'Cartan, S. A. M'Swiney, and W. H. Condell.

The following passed the Final Examination and were admitted Fellows:—A. Chalmers, B.Ch., Captain I.M.S., J. H. Dauber, M.R.C.S., S. English, C.M., and T. H. Hay, C.M.

THIS week Shoreditch Borough Council received a this week Shoreditch Borough Council received a deputation from the newly-formed Public Welfare Council, a non-political and unsectarian body, urging the adoption of the Notification of Births Act and the appointment of a health visitor. Miss Böge, superintendent of the district nurses, and the Rev. E. R. Ford, Rural Dean, pointed out that Shoreditch has the highest infantile death-rate in the metropolis, and is one of the three London boroughs which have not one of the three London boroughs which have not adopted the Notification Act. The question was referred to the Public Health Committee for consideration.

# NOTICES TO CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Instital, and to avoid the practice of signing themselves "Reader," "Subscriber," Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

#### SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Fereign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.02. Measrs. Dawson and Sons are our special agents for Canada.

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Oniounal Articles on Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Ben Nevis.—We have no knowledge of the subject to which

BEN NEVIS.—We have no knowledge of the subject to which our correspondent refers.

RESPICE FINEM.—The cost of radium is prohibitive, save to wealthy patients. Possibly any large retail chemist would quote a price for the quantity required.

TUBERCULOSIS IN IRELAND.

LADY ABERDEEN stated recently at the opening ceremony of a tuberculosis exhibition that she had received a letter from Sir Robert Matheson, Registrar-General for Ireland, in which he stated that the mortality rate from all forms of tubercular disease in 1808 was down by one decimal point. In every one of the three years 1905, 1906, and 1907 the rate per thousand of the population was 2.7, whereas last year it had fallen to 2.5 per thousand.

MR C H S One of the Table 1907.

of the three years 1905, 1906, and 1907 the rate per thousand of the population was 2.7, whereas last year it had fallen to 2.5 per thousand.

Mr. C. H. S.—One of the most abominable frauds, it would not be wise for us to "efer to it, as the proprietors would probably quote this journs" as having recommended it, without mentioning our strong condemnation. The medical man they refer to as an authority in the subject does not exist, at least we cannot find his name in the published list.

Dr. Statt Dutton.—Your paper is marked for early insertion, proof will be sent you in due course.

A Young Qualified Member.—Dr. W. G. Dickinson, West Hill, Pulney Heath, S.W. is the Hon. Secretary of the Society of Members of the Royal College of Surgeons, England. A letter addressed to him would enable our correspondent to learn all the information he required.

Mr. Lloth George has stated that medical men will not be entitled to rebate of duty on the petrol used in their cars. The cides, we believe, it, that they will be more than compensated by the number of persons who will get ill from financial worry brought on by the Budget.—Punch.

G. De G.—It is fairly common for a single microbe to produce multiple lesions of a most diverse nature—e.g., the pneumococcus, which, apart from the lung, may produce joint lesions, abscesses in any part of the body, and even ulcerative endocarditis. Another good example is afforded by the gonococcus which may produce joint affections, acute and chronic, in an extraordinary variety. In estimating the action of any given microbe, however, it is necessary to exclude the fallacy of a mixed infection. A most interesting and suggestive observation on this connection is the large number of different micro-organisms that have been found in ulcerative endocarditis. We believe the pneumococcus is often found in the lackrymal ducts, sometimes in purulent conditions.

# Meetings of the Societies, Tectures, &c.

WEDVESDAY, MAY 25TH.

MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Chemies Street, W.C.).—4 p.m.: Mr. R. Johnson: Clinique (Surgical). 5.15 p.m.: Lecture: Dr. R. W. Allem: The Pathology and Treatment of a Common Cold.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meschen); Eye (Mr. R. P. Brooks).

THURSDAY, MAY 27TH.

MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Chemies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture: Sir John Broadbent, Bart.: Relation of Arterio-Scleroeis to Aneurysm and Renal Disease.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynseological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Rays.

5 p.m.: Medical In-patient (Dr. G. P. Chappel).
Lecture: Mr. H. W. Carson Catarrhal Deafness.

ROYAL SOCIETY OF MEDICINE (SECTION FOR THE STUDY OF

ROYAL SOCIETY OF MEDICINE (SECTION FOR THE STUDY OF DISSASE IN CRILDREN) (20 Hanover Square, W.).—4.30 p.m.: Papers: Dr. Parkes Weber: Congenital Obliteration of the Bileducts with Cirrhosis. Mr. A. R. Thompson: Congenital Dislocation of Hip. Cases: Dr. Eric Pritchard: (1) Unilateral Hypertrophy of the Hand; (2) Symmetrical Helioal Fistulæ with Branchial Fistula in an Infant. Mr. Sydney Stephenson: A Case of Oxycephaly. Dr. George Carpenter: (1) Case of Congenital Morbus Cordis; (2) Specimen of Congenital Hypertrophic Stenosis of Pylorus. And other Cases.

CENTRAL LONDON THROAT AND EAB HOSFITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Mr. W. Wallis: Mouth and Teeth.

# Appointments.

BAZALGETTE, STDNET, L.R.C.P.Lond., M.R.C.S. First Assistant Medical Officer at the Bristol City and County Asylum,

BAZALGERTE, STENEY, L.R.C.P.Lond., M.R.C.S. First Assistant Medical Officer at the Bristol City and County Asylum, Fishponds.

Byrrs, G., M.B., M.S.Aberd., Medical Officer to the Aberdeen City Parish Council.

Fairmann, H. A. T., M.S.Lond., F.R.C.S.Eng., Surgeon to the Miller General Hospital for South-East London.

GILBERTSON, A. J., M.B., B.S.Durh., Honorary Surgeon to the Monkwearmouth and Southwick Hospital, Sunderland.

Jones, Jehn Ellington, L.R.C.P.Lond., M.B.C.S., L.S.A., Honorary Skiagraphist to the Orthopsedic Hospital for Crippled Children, Redland, Bristol.

MINCHIN, P. Dundas, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer and Public Vaccinator for the Etwall Diatrict of the Burton Union.

MORTON, WILLIAM BRITAIN, M.D.Lond., L.B.C.P.Lond., M.R.C.S., Medical Superintendent at the Wonford House Hospital for the Insane, Exeter.

NEWALL, W. A., M.D., Ch.B., D.P.H.Vict., Honorary Assistant Physician to the Chester General Infirmary.

PHILLIPS, JORN ROBERT PARRY, L.R.C.P.Lond., M.R.C.S., Junior Medical Officer at the Bristol City and County Asylum, Fishponds.

Revie, A., M.S., M.S.Glasg., Visiting Surgeon to the Kilmarnock Infectious Diseases Hospital, Exeter.

## Vacancies.

DALAILLES.

Abertillery Urban District Council.—Medical Officer of Health.
Salary, £350 per annum. Applications to William Gait. Clerk
to the Council, Council Offices, Abertillery.

King Edward VII. Sanatorium, Midhurst, Sussex.—Senior Assitant Medical Officer. Salary, £150 per annum, with board,
lodging, and attendance. Applications to the Hen. Sewestary,
19 Devonshire Street, Portland Place, London, W.

State of Western Australia Medical and Health Department.—
Medical Officer to the Central Board of Health. Salary, £400
per annum. Applications to James W. Hope, F.R.C.P.,
R.C.P.S.I., etc., Principal Medical Officer, Perth, Western
Australia.

Suffolk District Asylum, Melton.—Second Assistant Medical

Australia.

Suffolk District Asylum, Melton.—Second Assistant Medical Officer. Salary, £160 per annum, with board, furnished apartments, attendance, and laundry. Applications to the Medical Superintendent.

Darenth Asylum.—Mals Third Assistant Medical Officer. Salary, £150 per annum, with rations, lodging, attendance, and washing. Applications to the Superintendent, Darenth Asylum. Dartford, Kent.

West Norfolk and Lynn Hospital, King's Lynn.—House Surgeon. Salary, £100 per snnum, with board, residence, and washing. Applications to the Chairman of the Weekly Board.

Wye House, Buxton.—Assistant Medical Officer. Salary, £120 per annum. Applications to the Medical Officer.

# Births.

Howitz.—On May 19th, at "Lyme Regis," Hough Green, Chester the wife of J. H. Howitt, M.A., LL.B., M.R.C.S., L.R.C.P.,

MURISON.—On May 19th, at Burleigh Lodge, Erith, Kent, the wife of W. R. Murison, L.R.C.P., and S. Edin., of a daughter.

# , Beaths.

DRINKWATER.—On May 19th, at St. John's, Bicester, Orea, suddenly, William Drinkwater, M.R.C.S.Eng., L.R.C.P.Edin., aged 66.

HULL.—On May 19th, at Highfield, Rournementh, Hamiltonian

aged 68.

HULL.—On May 18th, at Highfield. Bournemouth. Harriette, daughter of the late Thomas Hull, M.D., of Boverley, Yorkshire, aged 89.

James.—On May 17th, Captain Henry Charles Melville Northage James, 98th Int., I.A., only and most dearly loved son of the late Dr. H. N. L. James, M.D., A.M.D., and Janie E. B. James, of synoope after swimming, near Swahage, aged 34.

Kebell, of Brisbane, Queenaland.

Kempell.—On May 18th, auddenly, Eatherine Agnes Kebbell of 26 Carlyle Square, S.W., widow of the late Dr. William Kebbell, of Brisbane, Queenaland.

Kempel.—On May 23rd, in his 70th year, Charles Marshall Kempe.

M.R.C.S., L.S.A., of New Shoreham, Sussex, after a short illness Miller.—On May 18th, at 33 Tavistook Square, Bloomsbury, Archie Ferguson Miller, M.B. Ch.B.Edin., only son (4 Melville and Sarah Miller, of Leievre Terrace, Adelaide. South Australia, aged 26.

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# The Valuable Properties "Lactonised" Milk.

Herter considers that putrefactive intestinal processes may be favourably influenced by fermented milk containing an abundance of lactic acid and lactic acid organisms.—Brit. Med. Journ., Dec. 25, 1907.

Metchnikoff states that some forms of lacticacid-producing miero-organisms inhibit the growth of certain pathogenic and putrefactive bacteria.—Medical Annual, 1908, p. 212. Emerson reports that lactic acid promotes peptic secretion and digestion, and that milk which has undergone lactic acid fermentation is a valuable food for infants and invalids in digestive disorders, especially those of a fermentative character, also in the dietary treatment of pulmonary tuberculosis and in the modified food of healthy infants.—New York Med. Journ., Feb. 8, 1908.

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, JUNE 2, 1909.

No. 22.

# Notes and Comments.

THE L.C.C. Committee have no doubt as to the crucial question of Who is to Call in · whose duty it is to call in medical the Doctor? relief for the defects discovered by the inspection. They have stated in so many words that "the responsibility for consulting a doctor is to be thrown upon the parents, and the Council purposes to disclaim all responsibility for the treatment prescribed or given." Now it seems to us that inspection without treatment is very much like notification of fevers without disinfection—that is to say, the primary step is rendered nugatory and worthless. A London physician not long ago related to the present writer a personal experience bearing upon the point in a village in his native county. A coachman told how one of his children had been sent back from the medical inspection with the advice that seven teeth should be drawn, adenoids removed, and glasses obtained for an error of eyesight. The man appealed to the physician for advice in so grave a domestic catastrophe, but as a matter of fact he obtained but scant comfort. This instance is by no means extreme. It represents a state of affairs in which a huge expenditure of public money may be practically thrown away, and an Act that is full of splendid potentialities reduced to the level of a laughing stock. Had the Government taken the medical profession into their confidence before adopting the measure, it is not unlikely that a good deal of the difficulty would have been avoided. In any case, some decision should be arrived at by the London County Council before long. The matter is complicated, but there should be no insuperable obstacle in the path to prevent a wise and just decision as to the best course to pursue. We hope before long to place a definite policy before our readers for discussion, and, meantime, we shall be pleased to hear any suggestions.

MEDICAL terminology is a standing source of wonderment and not a Fine Feathers little bewilderment to the uninitiated, and perhaps in these days, when everybody takes such a keen interest in medical matters, it is just as well that the profession should keep inviolate the sacred tradition, which in the past sufficed to cover a vast amount of clinical nescience. Moreover, those who strive to pierce the arcana of our science are not a little pleased with themselves when they are able to use the word epistaxis for

nose-bleeding, or to speak of cuticular abrasion when they mean a scratch. A considerable discussion took place at a recent trial in the High Court over the proper pronunciation of the word tinnitus, and the learned judge was quite flattered at having the pleasure of deciding that the classical usage demanded that that second "i" should be kept long. Such points, however, are refinements which, as a rule, do not trouble the profession much, and the laity who seek to imitate our speech even less. To this day the pronunciation of the word "enema" is almost as variable as a woman's whim, in spite of classical precedent and the common usage of the language. But we cannot say we admire the habit which has sprung up, especially in America, of compounding an amorphous pseudo-classical product to describe every variety of symptom and every phase of disease.

make castle Chron

Our contemporary, the Newcastle Chronicle, is much perturbed at the way in which medical terminology is getting beyond the

ken of plain paths, and we are bound to admit that if the examples they set forth can be described as that recognised by the profession generally, we ourselves are equally at a loss. The worst part of the case is that the alarming words are used to connote diseases which we should hesitate to class as morbid conditions, as otherwise we should find mankind little else than a pathological specimen. For instance we are told that "modern science declares this habit of compressing the eyebrows (in frowning) to be a nervous disorder, and baptises it 'synophriomania.'" Well, that certainly is enough to keep a man from scowling for the rest of his days. Then we learn that a person who bites his nails is afflicted with "onyxophagia," a word which strikes us as being as badly constructed etymologically as it is unnecessarily pedantic. The encouragement meted out to the meticulous in the phrase "Pull up your socks," should, we gather, be withheld lest the object of solicitude become a "kratopodomaniac," and Ouida's guardsmen who used to tug at their long moustaches at every crisis in their career should in the modern novel, be made to adopt some other gesture of perplexity, lest they be classified by the instructed as "mistakostrepsomaniacs." Lest we unduly cause alarm to those afflicted with habit spasm and other minor nervous derangements, we will not prolong the list.

Quack

ONE of the methods of the modern quack, after his advertisements Developments. have enticed a reply from a victim, is to keep "rubbing it in" to him if he does not bite as long

and as hard as the wily angler desires. Each week or two produces a freshly-worded letter reminding the hesitating one of the dangers of delay, and of the certainty of salvation by the advertised nostrum. Truth has just published a specimen of this method, which shocking or amusing, according to whether the matter is viewed philosophically or cynically. The firm cited by them is the "Dr. Van Vleck Co.," of Shoe Lane, E.C., and the fourth "follow up" begins with the question—"Do you realise that every month's delay is bringing you present the correction the bringing you nearer the operation table, or to a fatal termination of your disease?" and later it adds: "Are you annoyed at our writing to you?" "Annoyance," writes our contemporary, seems to be a quite inadequate term to express the feeling of the recipient of such an outrageous attempt to scare him into parting with half-a-guinea." We think so too. The callous and heartless indifference to every consideration, except that of obtaining an order, is revolting.

The Girl and the Curi.

RECENTLY there has been one of the periodical outbursts of malignant opposition to methods of medical advance on the part of the "anti" sections of society,

which took the peculiar form of denouncing the X-ray treatment of ringworm on the ground that, although the ringworm was cured, the patient's mental capacity was seriously stunted by the permeation of the brain by the rays. Of that we can only say that we are sure that X or any other kind of rays could have but little effect in dwarfing the intellectual development of the gentleman who made the outcry. As an off-set to this devastating influence of the rays, the Chairman of the Education Committee of the London County Council has come forward as an advocate of the treatment on the ground that the rays transform hair of the rat tail variety into curly locks of the most amatory description. Without posing as the possessors of special knowledge of the question, we may safely assert that among the young adults, at any rate, the popularity of Professor Röntgen is likely to advance by leaps and bounds if there is any truth in the assertion. The fact (if fact it be) that the brain is damaged would, among the jeunesse dore weigh lightly in the balance with the equally hypothetical fact that love-locks and kiss-curls followed the application of X-rays to the scalp. It is unfortunate that a necessary precedent condition to the appearance of these amorous stigmata should be complete depilation, but a rest cure " or a holiday abroad might be insisted upon by the beauty-culturist to tide over the period of baldness. From knowledge of the excesses to which human nature will advance in the cult of personal attractiveness, we have little doubt that the chin-straps "stuffed with fragrant herbs," and face-creams, and "skinfoods" would have little chance against any agent which would really cause Anglo-Saxon locks to assume the tortuous sinuosity of those of the sons of Ham.

# LEADING ARTICLES.

THE DIAGNOSIS OF UTERINE CANCER.

Or all problems that face medical investigation and medical treatment, there is none more difficult than that of cancer. In spite of the huge amount of skilled scientific labour that is being lavished upon the subject in many parts of the world, the ætiology appears to be little less obscure and the treatment little less hopeless than it was a generation ago. Now and then a gleam of light appears to break through the darkness, as happened, for example, when the definite influence of the X-ray tube upon recurrent nodules after operation was noted. Another encouraging fact is the influence of radium upon certain growths, and last, but not least, the complex action of ferments from internal organs as regards new growths. The greatest advance hitherto made in the campaign against cancer has undoubtedly been the recognition of the fact that early and free operative removal affords the best chance of recovery. That statement, indeed, sums up the situation so far as prognosis is concerned. The chances of a favourable issue depend, for all practical purposes, upon early operation, and that, again, upon early recognition. With regard to diagnosis in the first stages, it is often extremely difficult to recognise the condition. especially when it attacks internal organs, such as the stomach or uterus. At the same time there are various signs and symptoms, both general and local, which, taken in conjunction with the age and appearance of the patient, often warrant the surgeon to make an exploratory incision, although in themselves insufficient to justify a decided opinion as to the nature of the condition. In the case of uterine malignant growths it is a constant experience of hospital surgeons and gynæcologists that the disease has not been detected until too late for operative interference. In this way a number of valuable lives are constantly being lost, a fact that had long engaged the attention of the gynæcological societies, and, on the recommendation of the Obstetric Section, at the annual meetings, 1907 and 1908, of the British Medical Association, the matter was referred to a Special Committee for report. Under the able chairmanship of Dr. F. J. McCann, the Committee has submitted a full and exhaustive report, which has been since approved by the Council. This most important document was published in The Medical Press and Circular for May 12th, deserves the widest publicity amongst the classes who are chiefly brought into contact with uterine cancer in its early and curable stages, namely, medical practitioners, nurses and midwives. As a matter of fact, the Special Committee state that three-fourths of the uterine cancer cases that come under the care of the gynæcologists have previously been in the hands of their private medical attendants, who in not a few cases have undertaken treatment without local examination. The great source of danger, however, lies in what is aptly termed the "folklore of the menopause." Irregular bleeding about the period of life, associated with the cessation of menses, is treated lightly as "change of life," whereas it may, and often does point to conditions of the gravest kind. It is only by educating womankind generally, and nurses in

particular, as to the necessity of immediate skilled attention under such circumstances that any reasonable amount of security against the scourge of uterine cancer may be anticipated for coming generations. Should Dr. McCann's committee achieve nothing beyond the national advertisement of the risks of irregular uterine bleeding in middle life, she will have done a practical service to the community of which it is impossible to speak too highly. For the appeal to nurses and midwives they have issued a short and direct appeal, setting forth in simple language the facts of the case, and winding up with the following appreciation: - "The nurse or midwife who is told by a patient that she has any of these symptoms should insist upon her seeing a medical practitioner, in order that an examination may be made without delay. By doing so they will often help to save a valuable life, and will bring credit to herself and her calling." appeal to medical practitioners contains a clear detailed account of the symptomatology, methods of examination, forms of uterine cancer, microscopical examination, and operation. As this important document has already appeared in our columns, there will be no need to discuss it at length. It may be well, however, to reiterate the statement, made with all the weight of responsible and skilled authority, to the effect that, "probably the majority of cancer cases which are overlooked are examples of disease affecting the lining of the cervical canal or the tissues of the wall of the cervix." To this may be added the final recapitulation, which runs:—"(1) Attend to all symptoms suspicious of cancer, and instruct the patient on their importance; (2) examine immediately all cases of bleeding or abnormal discharge; (3) make a definite diagnosis, and do not wait for disease to develop; (4) urge immediate operation if the diagnosis be established. The practitioner who diagnoses cancer in an early stage, while operation affords probability of cure, renders a service to his patient as great as that rendered by the operator." This document should be carefully laid to heart and preserved for future reference by every practitioner who is likely to be brought into contact, directly or indirectly, with the class of cases referred to. It is to be hoped that the labours of the Committee will be rewarded by a future lessening of one of the constantly recurring but preventable tragedies of human life.

# CURRENT, TOPICS.

The L.C.C. and Voluntary Medical Fervice.

The proposal of the Education Committee of the London County Council to make use of the voluntary medical charities of the metropolis for the treatment of school children opens up issues of vital importance to medical practitioners throughout the Kingdom. Even though adequate fees for such treatment be paid to hospitals and dispensaries, it is clear that the charities would be making money out of the gratuitous services of the honorary staff, which are placed at the service of the poor and suffering, but not to be "sweated"—if we may use that term—for the convenience of charitable institutions and of public administrative bodies.

The resulting economic wrongs of the proposal, however, extend far beyond the mere trespass on the good nature of honorary staffs. There is the further fact often emphasised in these columns, namely, that the making of money by trading hospital organisation is to subvert trust funds subscribed for the clearly-defined purpose of relieving the sick poor. Finally, there is the unfair competition with outside general practitioners involved in the payment of fees to the hospitals or dispensaries. The mere amount of the fee does not lessen the injustice of the transaction; indeed, the larger the sum paid the greater the injury to the outside medical demand, from whose legitimate income the fee may in many, if not in all, cases be said to have been abstracted. We are glad to see that the Metropolitan Counties Branch Council of the British Medical Association has considered this important subject, and has issued a circular letter to London members. that document the situation is clearly discussed. The collective action of the profession is invited as follows:—"In the absence of the proper appointment of school medical officers, the Branch Council (in view of the foregoing considerations) is of opinion that the members of the staffs of the hospitals in London should unanimously oppose the project of the County Council." It is encouraging to find that the profession is taking steps to circulate conclusions whereby medical men may be guided in a wise line of conduct as regards their relations with public authorities, not to mention the defence of their own interests.

### An American Plan of Campaign against luberculosis.

AMERICA is the home of new ideas, and it is encouraging to find that they are not always confined to the problem of extracting the greatest amount of money from the national and international environment and resources. The fight against tuberculosis, for example, is conducted with continuous and unabated vigour. The great city of Chicago recently, by referendum, sanctioned the levy of a tax for the purpose of erecting and maintaining a sanatorium for consumptives, and Governor Hughes has just signed Bills authorising New York City and the counties of the State to establish similar hospitals. The number of cases reported during the last two years shows an apparent increase, but this the Health Commissioner attributes to earlier and more complete registration. The imposition of a general tax for the specific purpose of fighting tuberculosis is a principle that deserves careful attention by the British Government. From an economic point of view it seems reasonably certain that the gain to the national wealth would in the long run far more than repay the outlay. It would be interesting to have the considered opinion of an economist like Mr. Chiozza Money on so important a point.

# A Medical Centenary.

Among the many distinguished men the centenary of whose birth is being celebrated this year, one of special interest to our profession is Oliver Wendell Holmes. Though most of his fame is due to accomplishments in other than medical fields, it is not to be forgotten that Holmes was for many years an active member of the profession, and was always

proud of his connection with it. In a manner, his literary success left science the poorer, for there can be little doubt that had Holmes continued to work at scientific subjects in the spirit manifested by his early essays, he would have given the world contributions of importance. Of his medical achievements, his essay on the cause of puerperal fever is, of course, the most important, by reason of the remarkable prescience and courage which Holmes showed as a pioneer. His work "for the poor women" was always a source of wholesome pride to him, and it is curious now to look back to the bitter opposition shown towards his modest and unassailable conclusions by such conservatives as Hodge and Meigs. Holmes' fame as the discoverer of the nature of puerperal fever is somewhat overshadowed by that of Semmelweis, who reinforced Holmes' cogent reasonings by experimental proofs, but Holmes' labours must not be despised.

### Phthisis and Dust.

At the inquiry recently held at Sheffield by Mr. A. H. Lush, on behalf of the Secretary of State, to determine on the practicability and acceptability of new regulations for the grinding trades, the Home Office view was put forward by counsel, Mr. S. Pope, and medical witnesses, whilst various confederations of employers were represented on the other side. The figures mentioned by Mr. Pope were eloquent of the danger of respiratory diseases among grinders. Quoting from Dr. Sinclair White, he showed that whilst per 1,000 deaths among the male population, 144 were due to phthisis and 182 from other respiratory diseases, the mortality figures for grinders under the same heads were 345 and 295 respectively. Moreover, from the same source of information he announced that whereas 261 of the male population died between the ages of 35 and 55, and 391 after 64, amongst I grinders the numbers were 458 between 35 and 55, and only 140 after 64. Dr. Scurfield had shown that the phthisis rate among grinders was three times as great as that among the average male population of Sheffield, and from other respiratory diseases four times as great. After Mr. Pope had commented on the satisfactory spirit that had been shown by both masters and men in the consideration of the regulations, Colonel Hughes, who appeared for several large employers' associations, said that he advocated regulation, but feared that the proposed safeguards might hamper trade without having beneficial effects. Now the influence of the dust is the important factor—that is to say, that without dust phthisis need be no more common among grinders than among any other class of the community. But given dust, and irritation of the lung by its agency, inflammatory processes are set up which readily yield themselves as prey to so widely-spread an infection as that of tuberculosis. The dust generated in grinding processes consists of hard, sharp spicules, and, consequently, damages the lung far more than soft dust, like that of coal, and to this fact is due the enormous mortality of grinders. The indiscriminate spitting of workers should no doubt be stopped, and if tuberculous men are employed in these processes at all, which we should judge to be highly unwise for their own sakes, they should be supplied with spitting flasks or similar hygienic receptacles. But we hope the Home Office will not be drawn away from the question of dust by undue fear of infection.

# "Wireless" Surgery.

Ar a recent meeting of the Royal Institution of Great Britain Dr. Horace Manders showed a new method of dealing with warts, rodent ulcers birth marks and superficial epitheliomata. The apparatus, briefly described, consists of an ordinary scalpel, the blade of which is connected with a storage battery. The current, however, by a special device invented by Dr. Manders, is converted into a continuously maintained series of oscillations similar to those used in certain systems of wireless telegraphy. The application of this knife to the tissues combines the cutting with a cauterising action. This electro-cutting process, however, differs from the ordinary thermo-electric cautery in that there is less shock and no tendency to subsequent hæmorrhage. One interesting feature about the method is that the cauterising action is confined to an area represented by a fraction of a millimetre outside the surface of the knife, which remains cool throughout the operation. This new departure should prove of service for various surgical purposes, and it serves to remind us that the applications of modern electric methods are by no mean exhausted. During the past generation, for instance, quite a number of valuable electrical appliances have been introduced into the practice of medicine and surgery.

# "Wireless" Prescriptions.

THERE are still plenty of people living who can remember the sensation caused when the famous Windsor murderer was arrested when he arrived at Paddington Station, by reason of his departure in the train being communicated to the metropolitan police by means of what was then known as the "electric telegraph." In those days the occurrence caused as great a sensation as an arrest by eroplane or Zeppelin would create now. The Daily Telegraph has brought to light a story, if not as exciting, at any rate, so far as our knowledge goes, as dramatic in its details. This is no less than the recovery of a lady in Philadelphia by means of a prescription sent by "wireless" by her own physician in New York. The lady in question was a wealthy American, by name Mrs. Felman, and apparently preferring the ministrations of her accustomed attendant to those of a new doctor, when taken ill she "wired" to her medical man, who was crossing the Atlantic. for his advice. The latter sent back a message containing a prescription which had a wonderful restorative effect, and as the whole performance only cost ten dollars, the patient probably saved money on the transaction. The extension of the

radius and responsibilities of practice which this incident suggests are rather alarming. Hitherto the medical man has thought that he can at least be free from the troubling of the wicked by going down to the sea in ships, but now even that solatium is likely to be denied him. If consultation by Marconigram is to become at all common, it seems probable that suicide will offer the only effective alternative to being continually at the beck and call of wealthy neurotics.

The Orange Sanguineous.

WE are not sure as to what may be the attractiveness of the blood-orange, but the fact remains that that variety of the fruit possesses a great fascination for many buyers. The colour red has a quality that charms the eye in a peculiar manner, so that there is a general notion that red wine is "richer" and more nutritious than sherry or sauterne. Cunning advertisers are apt to extol the merits of inferior red wines on the ground that they are "blood-making" (whatever that may mean), and the analogy between the tint of hæmoglobin and that of claret or burgundy appeals irresistibly to the popular imagination. The same principle seems to apply in the case of the blood-orange, which is accounted more luscious than its less pretentious and more common-place brother. In this connection our contemporary, La Presse Medicale, has brought to light a curious trade trick which was brought to its notice by an unusual accident. In St. Petersburg recently a girl who had eaten a blood-orange was shortly afterwards taken with acute pain in the throat, accompanied with hæmoptysis. When examined medically it was found that she had a piece of a Pravaz needle imbedded in the pharynx, which in due course was safely removed. The connection between the blood-orange and the Pravaz needle was not at first sight clear, and the medical man pursued his inquiries till he traced the street-seller from whom the oranges were bought. When squarely tackled the man admitted that he was in the habit of injecting ordinary oranges with a solution of aniline dye by means of a Pravaz needle in order to palm them off on the unwary as blood-oranges. The secret was then out. For the sake of commercial integrity and the salubrity of the pharynx one can only trust that this custom will not invade our own shores.

# PERSONAL.

HIS ROYAL HIGHNESS THE PRINCE OF WALES, HIS KOYAL HIGHNESS THE PRINCE OF WALES, accompanied by the Princess, presided over the inaugural meeting of the Seventh International Cengress of Applied Chemistry at the Albert Hall on the 27th May last. Their Royal Highnesses were received by Sir Henry Roscoe, the honorary President of the Congress, and Sir William Ramsay, the President.

LORD GRENFELL presided on May 25th at the annual LORD GRENFELL presided on May 25th at the annual meeting of the Invalid Children's Aid Association, held at 16, Grosvenor Place, by permission of Lord Newlands Among those present were Sir Charles and Lady Fremantle, Lady Broadbent, Sir Alfred and Lady Fripp. and Mr. Warrington Haward.

PRINCESS ALEXANDER OF TECK was present on May 25th at No. 3 Grosvenor Place, lent for the occasion by Lady Esther Smith, at the sixth annual meeting of the Rural Midwives' Association, and distributed good the Rural Midwives' Association, and distributed good service certificates to a number of nurses on the conclusion of their term of service. Mr. Almeric FitzRoy, C.V.O., chairman of the Departmental Committee on the Midwives Act, presided.

THE Council for the Promotion of the Higher Training of Midwives held its annual meeting at The Deanery, St. Paul's, on May 25th, when the chair was taken by Lady George Hamilton.

THE forty-first annual meeting of the Queen's Hospital for Children, Hackney Road, was held at the hospital on May 24th, under the chairmanship of Lord William Cecil.

Dr. WILLIAM ENGELMANN, the distinguished Professor of Physiology in the University of Berlin, died on May 20th, at Berlin, at the age of sixty-five. Professor Engelmann was professor at Utrecht before his removal to Berlin.

THE National Hospital for the Paralysed and Epileptic (Albany Memorial), Queen Square, Bloomsbury, W.C., celebrates its jubilee this year, and will hold a festival dinner, with the Right Hon. the Lord Mayor in the chair, on June 10th, at the Mansion House.

The National Society for the Pievention of Cruelty to Children (by Royal Charter) held a great meeting in the Mansion House, London, on Monday, May 24th, when the Right Hon. the Lord Mayor presided, and the speakers included the Earl of Ancaster, Lord Alverstone (Lord Chief Justice of England), the Right Hon. Herbert Samuel, M.P., Sir Francis Channing, Bart., M.P., the Bishop of Kensington, and the Rev. Father Bernard Vaughan, S.J.

THE opening ceremony of the Berlin Tuberculosis Congress took place in that city on May 22nd, when Dr. von Bethmann-Hollweg, Imperial Secretary of State for the Interior, delivered the Inaugural Oration, describing the growth and development of institutions for experimental research in connection with tuber-

A CONFERENCE arranged by the Invalid Children's Aid Association will be held on June 22nd and 23rd. At the four sessions of the conference the chair will be taken successively by the Duchess of Sutherland, Lord Aberdeen, Dr. Arthur Latham, and Mr. Loch. All information can be obtained of the Secretary, Invalid Children's Aid Association, 69, Denison House, 296, Vauxhall Bridge Road, Westminster, S.W.

Mr. HOWARD MARSH, M.C., F.R.C.S., Professor of Surgery in the University of Cambridge and the Surgery in the University of Campriage and the Master of Downing College, presided at the annual dinner of the Medical Graduates' College and Polyclinic at the Trocadero Restaurant. Among those present were Sir W. Church, Sir D. MacAlister, Sir Y. MacAlister, Sir M. MacAlister, M J. Hutchinson, Sir A. H. Keogh, Inspector-General J. Porter, Mr. Bland Sutton, the Master of the Society of Apothecaries, Dr. Fletcher Little, Dr. Theodore Williams, Dr. A. Newsholme, and Dr. T. N. Kelynack.

Ar the forthcoming annual election to the Council of the Royal College of Surgeons the members who retire by rotation are: Mr. A. W. Mayo Robson, Sir W. Watson Cheyne, and Mr. R. Clement Lucas. It is understand that Mr. Harrison Cripps and Mr. W. W. H. Jessop, senior surgeon and senior ophthalmic surgeon respectively at St. Bartholomew's Hospital, are intending candidates for election. The requisite forms to be filled up by Fellows of the College who are desirous of standing for election must be delivered at the College not later than June 4. AT the forthcoming annual election to the Council

# A CLINICAL LECTURE

ON

# THE CLINICAL FORMS OF ARTERIO. SCLEROSIS.

By PROFESSOR H. HUCHARD, M.D.,

Of the Faculty of Medicine of Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

Although the question of arterio-sclerosis has been under discussion for the last forty years, it is still far from settled, as has been shown by various recent contributions. This is because it is one of the questions that are not based on any exact definition on which observers can come to an agreement. If, as I suggested, there are few contradictory data but many contradictors, this may be ascribed to the fact that some observers regard arterio-sclerosis merely as an anatomical lesion, and do not pay the clinical evolution the attention it deserves.

To hold that the disease is constitutional and at the same time that it is limited to the smaller blood-vessels, or to admit that it invariably commences by endarteritis or mesarteritis, is both to unduly narrow and also to unduly enlarge its scope. To confuse it with atheroma is to take the lesion for the disease. Then, too, to maintain that we may hope to learn the pathogenesis of arterio-sclerosis by experiments with agents that heighten arterial tension is to ignore the fact that hyper-tension is in no wise a necessary accompaniment of arterio-sclerosis, overlooking the fact that we meet with cases of arterio-sclerosis which run their course with a lowered tension (intestinal arterio-sclerosis).

To assert on the other hand that arteriosclerosis is under the dependence of the nervous system, in other words, a tropho-neurosis, appears to me to be begging the question by mixing up the pathogenesis with the ætiology.

Let us turn now to hypertension, which is so often invoked as a cause of arterio-sclerosis. Whatever its importance may be it is far from being the primum movens of arterio-sclerosis in the sense of being directly a consequence of the intoxication, and therefore the underlying influence in determining the clinical course of the disease. Arterial cardiopathies commence with intoxication, they continue with intoxication, and they end with intoxication. Without overlooking the manifold and grave dangers associated with hypertension, I hold that it does not explain the whole symptomatology of arterio-sclerosis in which the disturbances due to the intoxication, along with the cardiopathy, are the principal factors. When hypertension is consequent upon intoxication, the latter is usually of alimentary origin, no better proof whereof is necessary than the toxic dyspnœa, the predominant symptom in arterial cardiopathies, which disappears so readily on milk, or even lacto-vegetarian diet.

With reference to the cases of arterio-sclerosis which run their course in hypotension it appears to me that the disease is consequent upon what, seven years ago, I called "portal hypertension." These patients suffer from "abdominal plethora" with enlarged liver, are liable to recurrent pulmonary congestion and have a readily dilatable heart. The damaged liver no longer

fulfils its antitoxic function, so that toxic substances find their way into the circulation and irritate the walls of the vessels. This stasis and portal hypertension are amenable to abdominal massage which yields excellent results.

On the strength of Josué's experiments, sundry observers have tried to show that arterio-sclerosis is of suprarenal origin, but my own view is that experiments cannot possibly afford us an explanation of the pathogenesis of arterio-sclerosis, for the simple reason that although we may succeed in determining an arterial lesion, we cannot reproduce a disease with all its sequelæ. To set up generalised arterio-sclerosis in an animal we should have to inject various predetermined toxins along with the hypertensor agents, indeed, I need not insist on the differences between experimental or spontaneous atheroma and arterio-sclerosis. Atheroma remains limited to the large trunks and medium-sized vessels, whereas arterio-sclerosis, a disease of intoxication, affects especially the viscera. This difference in the lesions explains how it is that atheromatous patients remain vascular subjects with a minimum of symptoms, whereas the subjects of arterio-sclerosis promptly become "visceral" subjects, and are exposed sooner or later to the gravest toxic accidents.

Of some 15,000 cases that I have collected, I have carefully investigated 1,980 with the following results: The most frequent ætiological factor was gout and its manifestations, gravel lithiasis (393 cases); then rheumatism (254 cases); syphilis (237 cases); alimentary habits (205 cases); and tobacco (188 cases). There were 57 cases following infective diseases, diabetes (51 cases); alcoholism (31 cases); malaria (23 cases); and the menopause (21 cases). Moral and nervous causes only accounted for 19 cases.

Whatever we may think of the value of statistics, these have an eloquence of their own. They show that tobacco, syphilis and alimentary habits cannot be discarded, as certain authorities would have us do, from the ætiology of arteriosclerosis. The present confusion on the subject of arterio-sclerosis is especially due to authors not having sufficiently defined the limits of the disease which they seek to describe on the strength of its anatomical characters rather than by its clinical characters. If we keep to the clinical aspect we shall recognise three principal forms of cardiacsclerosis—cardio-renal, which is the most frequent; cardio-sclerosis of myovalvular origin; and sclerosis of the cardio-bulbar type (Stokes-Adams' disease).

With regard to its clinical course, cardiosclerosis may be divided into four stages: a first stage characterised by heightened arterial tension of toxic origin (præ-sclerosis); a second, cardioarterial stage with cardiac degeneration; a third, mitro-arterial and a final stage, which may be wanting, characterised by disturbances due to cardiectasis.

The dominant symptom during the præsclerosis stage is hypertension, presumably of renal origin, this prepares the way for, and causes, the vascular lesions of arterio-sclerosis. At this stage the arterial lesions are reduced to a minimum. so that the disease is perfectly curable. This stage is characterised by hypertension, visceral meiopragia and intoxication, the last-named being consequent upon renal insufficiency, which is the constant and early symptom of arterial cardiopathies, even in the absence of albuminuria. The painful symptoms comprise angina pectoris, rheumatoid pains in the limbs, side stitch and intercostal pain, the arterio-spasmodic origin of which is shown by the success of the vaso-dilatation treatment inaugurated by Weber and Jaquet.

Towards the end of the first stage cardiosclerosis is accompanied by tachycardia and arhythmia. This tachy-arhythmia is soon accompanied by a bruit de galop, which is not easy to distinguish in consequence of the rapidity of the heart-beat. Then, too, there is alimentary toxidyspnœa, which must not be mistaken for uræmia. The latter does not disappear rapidly as does the dyspnœa of cardio-sclerous patients on a suitable

This brings me to speak of the asthma and emphysema which it used to be thought might determine asystole by dilatation of the right heart, but personally, I have never seen asystole follow asthma or emphysema. Asystole only supervenes in asthmatic, emphysematous subjects who have developed arterio-sclerosis. The heart only becomes dilatable in consequence of preexisting myocardiac lesions.

In the myovalvular form, in addition to the arterial lesions, we get lesions of the aortic or mitral valves. Clinically, this form manifests itself by the same toxic or meiopragic phenomena. The mitral lesion may lead to narrowing or insufficiency of the auriculo-ventricular orifice, a tolerably frequent consequence. In order to be enabled to distinguish the physical signs of mitral stenosis it is necessary to lower the aortic tension by rest, diet and hypotensive medication, and to slow the heart by giving digitalis. We then detect doubling of the second sound, attenuated and intermittent, presystolic roulement and diastolic snoring, as in all arterial cardiopathies. The functional disturbances are here of capital importance for mitral stenosis, itself productive of dyspnœa, is doubly so when complicated by arterio-sclerosis.

Mitral stenosis in the subjects of arteriosclerosis is accompanied by symptoms which are not met with in pure mitral stenosis, they being consequent on the extension of the arteriosclerosis to various organs and tissues. I need not insist on aortic stenosis and insufficiency, but it must not be forgotten that it is not the aortitis that does the harm in aortic insufficiency in the subjects of arterio-sclerosis, but the kidney which by the imperfect discharge of its functions favours the production of toxic disturbances. The disease is in the heart, but the danger is in the arteries, and especially in the kidney.

Arterio-sclerosis may be of aortic origin, as in syphilitic arterio-sclerosis, and it may remain for some time apparently a merely local disease which, however, in the course of months or years

is followed by the usual symptoms of arterial cardiopathy.

Many physicians attach great importance to the sinuosity and hardness of the temporal artery as a sign of the existence of arterio-sclerosis, but this state of the temporal artery is met with in pure hypertension without any vascular lesion, or it may be due to atheroma without concomitant arterio-sclerosis. Cerebral hæmorrhage again has been put forward as a consequence of arteriosclerosis, but it only occurs when the disease is complicated by interstitial nephritis.

Then, too, we must distinguish between the senile heart and the arterio-sclerous heart, for the proliferation of connective tissue that takes place in the cardio-vascular system of the aged, presents many points of difference with that of arterio-sclerosis.

With regard to the therapeutical indications, I need only remark that during the first stage, that of so-called præ-sclerosis, we must deal with the intoxication of renal origin and the hypertension, the former by milk or lacto-vegetarian diet, and the administration of diuretics: theobromine and thyminic acid: the latter by massage, muscular gymnastics, carbo-gaseous baths and vaso-dilators.

In the second stage milk diet is de rigueur, or we must, at any rate, reduce the introduction of alimentary toxins to a minimum.

In the mitro-arterial stage we must enjoin milk diet and the administration of theobromine and digitalis, diminishing the amount of liquids. At this juncture I should like to enter a protest against the abuse of certain drugs, which are only indicated at the end of the first stage and during the second stage, such as iodide of potassium, anti-sclerous serums, and certain mineral waters.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for rext week will be by Professor Julius Dollinger, M.D., Professor of Surgery at the University of Buda-Pesth. Subject: "The Extraction of the Roots of the Trigeminal Nerve, as an Operation substituting the Extirpation of the Gasserian Ganglion."

# ORIGINAL PAPERS.

# THE ESSENTIALS OF PHYSIOLOGICAL HISTORY.

By DAVID FRASER HARRIS, M.D., B.Sc.Lond., Lecturer on Physiology in the University of Birmingham.

ABSTRACT OF LECTURE II.

THE views of Aristotle on respiration and animal heat were first of all explained. Aristotle believed that air entered the heart to cool it; its innate heat tending to become "excessive." This idea that breathing was to cool the heart lingered in physiology until after Harvey's time. Galen knew of the diaphragm and intercostal muscles as respiratory, that division of the recurrent laryngeal abolished voice, and that division of the spinal cord compromised breathing. Vesalius in 1540 showed that artificial respiration would resuscitate a heart that had ceased beating.

Von Helmont (1577-1644) virtually discovered carbon dioxide as gas sylvestre about 1640. To Fabricius the object of breathing was generation of animal spirits, cooling the heart and getting rid of "fumes." Harvey's treatise on respiration was

Note.—These Lectures were delivered in the University of Birmingham during May, 1909. Abstract of Lecture I. appeared in our last week's issue. Lecture III. will appear in our next.

lost when his rooms in Whitehall were ransacked in 1642 by the soldiers of the Parliament.

The views of Thomas Willis (1621-75), a pupil of Harvey, were then described. The experiments by Boyle (1660) with the air-pump showed that in a partial vacuum a sparrow and a mouse died, and the flame of a candle went out. Hooke's experiment of 1667 before the Royal Society demonstrating life supported by artificial respiration was the next contribution. Borelli in Italy correctly solved several problems in the mechanics of respiration, while Richard Lower, of Oxford, shed light on its chemical aspect. John Mayow, of Oxford, virtually discovered oxygen in a physiological sense as "nitro-aerial particles." His conclusions were far ahead of their time, and his work misunderstood and forgotten. G. E. Stahl (1668-1723) put the hands of the clock of research back by explaining combustion and breathing in terms of "phlogiston."

The Rev. Stephen Hales (1677-1761) was one of the first men of science to understand ventilation. His ventilators were introduced into prisons, hospitals, the holds of ships and mines.

Joseph Black (1728-1799), at Edinburgh, enunciated the doctrine of "latent heat," and first showed the rôle of carbon dioxide in chemistry. Experiments of Hales with regard to an apparatus for purifying the air breathed over and over again in mines where the CO2 was absorbed by potash, suggested to Black the study of this gas. Priestley, Lavoisier, Cavendish and Crawford all acknowledge their indebtedness to Black. He first explained the formation of calcic carbonate in flime water. Black is generally recognised as the "Discoverer" of carbon dioxide—the discoverer of its fundamental chemical and physiological properties.

In 1772, Daniel Rutherford, a professor at Edinburgh, virtually discovered nitrogen as

'' mephitic gas.''

Joseph Priestley, on August 1st, 1774, by the use of a "burning glass" caused oxygen to separate from "mercurius calcinatus per se." He did not quite understand what he had discovered: it was oxygen or "oxygine," as Lavoisier called it; to Priestley it was "dephlogisticated air." Lavoisier, untramelled by the "phlogiston" theory, began where Priestley left off, and showed that animal heat and the heat of combustion were alike due to the oxidation of carbon and hydrogen in the animal and in the inflammable substance respectively. Scheele, the Swede, really knew of oxygen in 1773, but his experiments were not published until after Priestley's, and Priestley knew nothing of them. Lavoisier invented the first or ice calorimeter. Nitrogen he called "azote," the substance that would not support life. Adair Crawford's theory of the rôle of the blood in maintaining a constant temperature was described; it was based on errors in calculating the specific heats of arterial and venous blood; to him is due the water calorimeter (1788).

The important work of Pettenkofer and Voit, of Münich (1866), and the contributions by Bohr of Copenhagen; Haldane of Oxford; and Leonard Hill of London were alluded to.

The history of the extraction of the gases of the blood (Magnus, Davy, Liebig and Pflüger) was summarised. The history of growth of knowledge of tissue respiration was briefly gone into, as also that of the respiratory importance of

hæmoglobin (Funke, Hoppe, Vierorht and Stokes). A resumé of the history of animal thermometry brought the lecture to a close.

# AN EXPERIMENT TO DETERMINE THE VALUE OF COLOURED UNDER-CLOTHING FOR SOLDIERS. (a)

By Capt. J. M. PHALEN

AND
LIEUT. H. J. NICHOLS,
Of the Medical Corps of the United States Army.

WE wish to say frankly at the outset that our object in presenting this paper is to profit by discussion rather than to attempt to instruct and, accordingly, we shall simply give an explanation of what is being done by the U.S. Army in the Philippine Islands in regard to the effects of tropical light, in the hope that this account, even if it contributes nothing, may be of some interest here in India where the climatic conditions have given rise to so many observations on this subject. During America's short occupation of tropical countries, a number of men, but notably Major Woodruff, of the Army Medical Corps, have become impressed with the possibilities of the effect of tropical light on white men and have brought this question into prominence. During England's long rule in the Tropics, however, the question has been considered more thoroughly and the immediate cause of the work to be outlined is found in two articles by Sambon and Duncan in the Journal of Tropical Medicine, of February and March, 1907. Sambon, it will be recalled, photographed the spectrum of an electric arc after passing the rays through the skin of a native of India, and then constructed wearing material for white men which had the same effect. Duncan's article was promoted by Sambon's, and he gave practical instances from India to support Sambon's theories, with recommendations in regard to clothing. These articles came to the notice of the Inspector-General of the Philippines Division, and he urged that the matter be looked into. General Wood approved, with the remark that while the effects of the sun in these islands and in the hotter portions of India are very different, yet it is believed that it would be wise to have a careful investigation made as to the advantage to be derived from the use of underclothing of a colour to protect against this (the actinic) ray."

THE EXPERIMENT.

These recommendations were approved at Washington and on advice of the Surgeon-General 5,000 suits of the regular issue underwear and 5,000 hat linings were dyed orange-red, the colour selected being, in the words of the Surgeon-General, "as nearly as practicable that used by photographers to prevent chemical effects of the light used in their dark rooms and for the same reason." The matter was turned over to us for execution, with directions that half of a company wear the coloured underwear and the other half to act as controls, and that a special medical officer stay with the troops for a year to observe the results.

The question may suggest itself, why should this experiment be made? Why not adopt the clothing outright? For us there are two reasons. In the first place the whole subject is in a somewhat hypothetical state. Neither the effects of

(a) Abstract of Paper read before the Indian Medical Congress, Bombay, February, 1909.

light nor the remedies proposed are on any such firm ground as the need for sterilised water or mosquito nets and light clothing in the Tropics. Enthusiasts who have perhaps more fondness for ethnology and analogy than actual experience make it seem quite plain. Others, perhaps, equally biassed, hold that the ills of tropical life are all included in the results of infection, heat and moisture. Take, for instance, a sunstroke as an example of the unsettled state of opinion. Duncan's article is entitled "The Actinic Theory of Sunstroke," and he says there can be no doubt that this actinic theory of sunstroke is the correct one. Manson, however, says that in his opinion Sambon's pypothesis of the infectious nature of siriasis has more in its favour than any of the many theories that has been based on a purely thermic ætiology. On the other hand, Rogers has shown, quite conclusively, it seems to us, that sunstroke is co-related with a high temperature and a certain degree of moisture in the air.

EFFECT OF ACTINIC RAYS.

In the second place we have to deal with soldiers and with soldiers in the Philippine Islands, This fact narrows the field at once. If the ultraviolet rays are injurious, it would undoubtedly be of value to wear coloured glasses to protect the retina; this is not feasible, however, for soldiers who would discard them on the slightest provocation. Again soldiers' clothing, for military purposes, is already to a certain extent pigmented and certain articles of clothing, such as the hat are fixed beyond change. Again in the Philippines we have practically no sunstroke, although it is common enough in some seasons and places in the United States.

It seems desirable, therefore, that we should satisfy, ourselves of the value of these suggestions for our own conditions and environment before acting finally upon them. Granting, for the sake of trial, that the actinic rays are injurious to the white men's tissues, how can we measure and demonstrate these effects. Sunstroke must be excluded as it is so rare; heat exhaustion is by common consent admitted to be due to heat rather than light. There remains a group of complaints called sun traumatism by Manson, and we have a small number of cases which may be included in this group. The chief results, however, must be sought for under the rather vague headings of neurasthenia and anæmia.

Neurasthenia.—If loss of physical and mental tone is measurable in objective terms it has seemed to us that dynamometer and blood pressure readings should show it, and these are the special tests, one for the voluntary muscle nerve apparatus and the other for the involuntary, that we expect to rely most upon. These observations will be made at least every three months.

Anæmia.—Some work has already been done by medical officers on the blood, and among nearly 100 men observed for over a year by Capt. Wickline, there was an average loss of over 10 per cent. hæmoglobin; an increase of the number of red blood cells, and an increase of lymphocytes and decrease of polynuclears. Similar observations will be made on the men wearing coloured underclothing, and on controls.

### RESULTS OBTAINED.

Now 500 subjects with 500 controls have been selected from cavalry, infantry, and artillery in our widely-separated posts. After excluding men

with long tropical service and those who are for any other reason unfit, every other man in order of height has been ordered to wear the clothing and the other men to serve as controls. A special medical officer has been detailed at each post to keep the records and to observe the results. The records are kept on cards which require, beside, the special test mentioned, the following data: Age, height, nativity, colour of hair, colour of eyes, complexion, length of service, and length of tropical service; an account of previous medical history and medical history during the test; weight, pulse and respiration.

In addition to these 500 men, 75 men are to be studied more closely with the ergograph and blood pressure readings for effect of short exposures to the sun. A number of officers of the line and staff are also wearing the clothing and their opinion will be considered.

Some information has already been obtained by exposing photographic plates to sunlight after passing through the articles of our uniform. The most interesting result is that our campaign hat, which is apparently fixed for field work, is as opaque to chemical rays without a red hat lining as with it. As the lining increases the heat, it seems doubtful if the hat lining will be of any benefit for the campaign hat; for caps there is a slight difference for the orange-red lining over the ordinary lining coloured green, brown, or red. Our blue flannel shirt, however, is not as protective chemically as we had believed. We have other prints showing the absorptive power of each article of clothing. Other questions have come up such as the fastness of the dye, the increase of heat of coloured clothes, the relative value of a less gaudy garment, etc.

At present we are merely in a receptive mind, and while we believe that at the end of this test we can give some definite opinion on the merits of coloured underclothing for our soldiers, at present we are in the strictly agnostic mood.

# SUPRA-PUBIC PROSTATECTOMY. (a)

By G. P. NEWBOLT, F.R.C.S.Eng.,

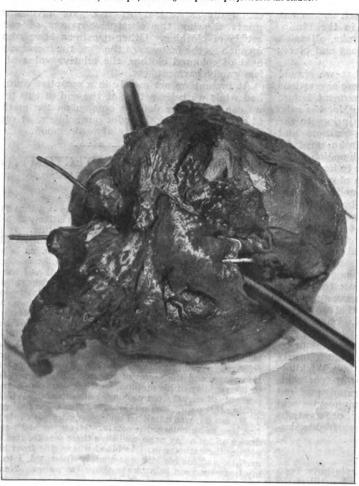
Surgeon, Royal Southern Hospital, Liverpool,

(Concluded from page 526.)
The chief danger in the operation is the fact that the patient's kidneys are diseased, and this is likely to tell more in this class of case than in any other. It is also rather difficult to ascertain beforehand what the condition of the patient's kidneys is when, as is so often the case, cystitis is present. Again, he is often the subject of chronic chest mischief; and, as I have said, it is as well to have your patient under observation for a time in order to wash out the bladder, determine the state of the kidneys, and, if possible, improve the general condition. In a doubtful case it is a question whether preliminary supra-pubic drainage is not the safer plan. I see Freyer has done it three times in his last 119 cases. In the first place, the cystitis can be treated, and, secondly, acute retention is at once relieved. Again, time is saved at the second or enucleation stage, and the secret of Freyer's success must lie in the rapidity of his method, which lessens shock and prevents ill-effects from prolonged anæsthesia. writing this paper, and on October 15th last, a patient, T. B., at. 63, was admitted under my care with retention due to an enlarged prostate. His urine had been drawn off for a day or so, and then there was trouble in getting the catheter in. As blood was oozing from his urethra, and his bladder was acutely distended, I told my house-surgeon to aspirate above the pubes. Next

<sup>(</sup>a) "Liverpool Medico-Chirurgical Journal," January, 1909.

day he filled up again, so I opened his bladder above the pubes, washed out some rather foul urine, and drained him with a view to subsequent prostatectomy. At the operation his bladder was enormously distended, and the finger felt the sacrum plainly. The prostate itself was pushed forwards under the pubes,

(6) A variety in shape; the elongated portion projects into the bladder.



(2) The same specimen with probes passed down the ejaculatory ducts.

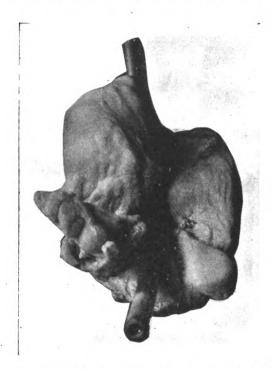
so that only the urethral opening could be felt from the interior of the bladder, though the gland itself could be plainly felt from the rectum; after drainage the prostate returned to its normal position, and could be felt as a distinct projection into the bladder. This man's condition slowly improved, his pulse fell, and his tongue became moist. Any operation for removal of the prostate at the time of his admission would, I am convinced, have proved fatal. His urine contained 1.5 per cent. of urea. On November 3rd, eighteen days after the supra-pubic drainage, I removed his prostate. The actual enu-cleation took about four minutes, and he was under the anæsthetic (which he took badly) for twenty minutes. There was more hæmorrhage than usual, and I washed hisbladder out with very hot water passed through a catheter in his urethra until the washings were clear. The prostate weighed two ounces, and the supra-pubic wound needed enlarging before the tumour could be delivered. His pulse ran up from 80 to 124 the same evening, but since that date he has had no further trouble, and is conva-

lescing favourably.
What are the after-results if the operation is a success? Does it prove a complete cure? The answer is Yes in the great majority There are, however, of cases. instances in which this is not so. There may be frequency of micturition after operation, stricture or a sinus giving trouble for a varying period; stone may form as a phosphatic deposit about the site of enucleation; there also may be loss of sexual power. With regard to stricture, I fancy that some degree of contraction at the point at which the urethra is torn is the cause of this trouble, and in all probability it may be avoided by the passage of instruments after

operation.

A typical instance is that of a man, at. 52—fairly young for this operation—whose prostate was removed abroad in March last. As a result he was unable to hold water at night, and the most he could retain in the daytime was three ounces. This, of course, prevented his keeping any social engagement. Under an anæsthetic, I forced a Lister's bougie through an obstruction about the triangular ligament, guiding it with my finger in the rectum, and then dilated him up to the full size, i.e.,  $\frac{15}{18}$  Lister. Ten days later I passed a large Lister's bougie with eucaine. As a result of this treatment he was able to retain nine ounces of urine, the dribbling disappeared, he was quite comfortable, and, I think, will have no further trouble. Another case was one of my own, where I did

not pass an instrument at all after operation; as a result, he got complete retention, and I had to torce a Lister's bougie through. After passing this three or four times, there was no after-trouble, and the man is quite well at the present time, four years after operation. The peculiar thing about this case was that the suprapubic wound and the stricture both closed tightly at the same time, and though I tried to get a probe the same time, and though I tried to get a probe through and open up the supra-pubic wound, I failed to do so. On the other hand, when there is trouble in getting the supra-pubic wound to close, the passage of a catheter very soon puts this right. I think that the cause of this stricture lies in the removal of membranous urethra; Freyer says he does not get this complication, and it may be that he is careful not to remove more urethra than he can help. In future I intend paying more attention to this point. I think the persistent sinus is rare: the first case I did had a little trouble, but it cleared up after passing a catheter once or twice. Only the other day I removed three stones from the bladder of a man with an enlarged prostate; yet in spite of this the supra-pubic wound closed quite easily. If the



(3) Parts removed from a gentleman, æt. 63, in whom they shelled out easily, leaving portions of the urethra behind. The patient is quite well after three and a half years.

phosphates form at the edges of the supra-pubic opening, the administration of boracic acid internally

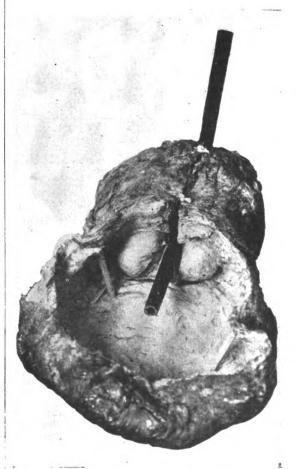
soon clears this away.

The question of the loss of sexual power must be considered. I am told that Freyer's youngest patient is only 46; and if one is going to operate upon men at this age, they naturally will want to know something about this point. I am also informed the man in question is quite sound. If you examine the specimens, in some the ejaculatory ducts are to be seen torn across; in others they are not. This depends upon the sort of case you have to deal with: if it is a total enucleation in one mass, as in most of the specimens shown, the ducts are torn; if the adenomata shell out, leaving the greater part of the urethra, the ducts may be uninjured.

Frequency of micturition sometimes remains for a while, together with a little dribbling of urine. The passage of a catheter once or twice will usually improve matters, and it is necessary when operating to keep close to the prostate and so avoid injury to the neck of the bladder.



(7) The reflected portions are pieces of envelope or surgical capsule separated after removal. Microscopically they consist of prostatic



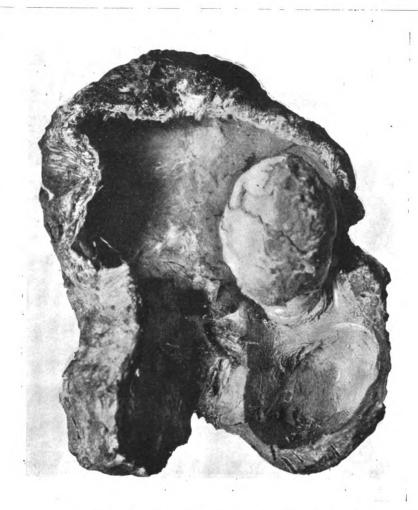
(8) Bladder from patient with enlarged prostate, showing the sub-mucous projections of the prostate into the bladder.

Epididymitis is a frequent complication, but does

not give rise to much trouble.

Mortality.—We have already touched upon this point, which must always be a consideration in the class of patients dealt with, i.e., unsound men. Freyer says that few of his patients were free from one or more complications, such as cystitis, stone in the bladder, pyelitis, kidney disease, diabetes, heart disease, thoracic aneurysm, chronic bronchitis, paralysis, hernia, hæmorrhoids, etc., so that his success is very wonderful. Whilst, however, considering the risk of operation,

pain. I taught his son how to wash out his bladder, and this gave him a little relief. Gallic acid internally usually checked the hæmorrhage for a time, but his condition during the last three or four years of his life was most pitiable. He had nine years' catheter life, and died at the age of 74. I have little doubt that operation at the onset of catheter life would have saved him infinite pain, and at the same time would have prolonged his life. Again, a man may go on with a certain amount of discomfort until he is very old, and then he gets retention. However careful one is,



(9) Same specimen showing the prostate enucleated from the left side and turned forward, leaving the sheath behind.

we must not forget the other side of the picture. The discomfort—or, I should rather say, absolute misery—that a man goes through who has complete retention can only be realised by watching a case of this sort. Take the following instance. An old gentleman, with an enormous prostate and, as the result of straining, a large hernia, with a bunch of hæmorrhoids complicating matters, also had a big rectal polypus. He was nervous and would hear of no operation. I managed, with the help of cocaine, to secure the rectal polypus, but I never managed to get possession of his prostate. I saw this man on and off for several years, and he died in the greatest misery. His bladder got into the most irritable condition, so that he passed his catheter every half-hour in attempts to relieve himself; he bled at intervals, and was never free from

the use of che catheter speedily upsets the balance, and he quietly goes downhill; his tongue becomes dry, he wanders in his mind, and dies in an uræmic condition. Here there has been no special indication for operation early on, and it is useless at the later stage, and he does not suffer much.

I can hardly leave the subject without making a few remarks about the pathological anatomy of the gland in question. There is an excellent paper by Cuthbert Wallace on the subject in the British Medical Journal, January 30th, 1904, to which I may refer you. There is no doubt that the parts removed differ according to circumstances. In the majority of cases the whole enlargement, including the prostatic urethra, is removed, together with a variable quantity of envelope or capsule derived from the expanded portion

of the prostate, which has been stretched and flattened out by the growth of the adenomata from within. The amount of envelope left behind depends upon the depth at which the enucleating finger effects its entrance. In some cases adenomatous masses only are shelled out laterally and from behind, and portions of the urethra remain behind (Specimen No. 3). In no instance should the recto-vesical fascia be opened up or the venous plexuses be injured; and a portion of envelope of prostatic tissue is usually, if not invariably, left behind, which accounts for the little bleeding and the absence of extravasation in the great

majority of cases.

The envelope or "surgical capsule" is a pathological formation, and it follows, I take it, that it is impossible to remove a normal prostate, for this envelope is not present, so that the recto-vesical fascia would be injured and fatal hæmorrhage or extravasation would occur. That prostatic tissue is left behind has been proved by examination of the "shell" left arter enucleation of the prostate in the post-mortem room.

I have specimens showing this.

# **OUT-PATIENT'S ROOM.**

ST. THOMAS'S HOSPITAL.

Fracture of the Atlas.

By Mr. EDRED CORNER, M.C., F.R.C.S.

A CABMAN, æt. 50, was dozing in a chair on a Sunday afternoon, and, in nodding, he rolled out of his chair into the corner of the room. His head was flexed at the time, and there was no great violence used. The pain at the time was described as "simply shocking." It was situated high up in his neck. He was assisted to rise, though there was no paralysis or anæsthesia, etc. Having been put to bed, he remained there rather out of expediency than actual necessity. It was not till the fifteenth day that he came to the out-patients' department at St. Thomas's. When seen there he was found to have pain and rigidity in the upper part of his neck. He also complained of pain along his right great occipital nerve. A skiagraph was taken which revealed fractures of the pedicles of his axis. He was treated with quiet and rest, followed by massage. He commenced to drive his cab about again in twelve weeks' time. Nearly seven months after the accident the movements of his head were quite good, but he still complained of curious numb feelings over the area of his left great occipital nerve.

In giving a description of the injury, Mr. Corner said: The anterior skiagraph of the spine showed nothing. The lateral view shows very distinctly a fracture of each pedicle. That on the right side is displaced a little upwards, so that the ends of the fragments are seen above those of the left pedicle. The fact that the fragments of the broken left pedicle are but little displaced is seen in the obscurity which it leads to in the lower part of the fracture. The greater displacement of the fragments of the right side explains the greater involvement of the corresponding great occipital nerve. The line of the fracture is as follows: Above it starts at the outer and posterior part of the superior articular processes of the axis and passes downwards and backwards, to end on the inferior surface of the pedicle just in front of the inferior articular process. The arch of the axis is in consequence completely separated from the body. It is, however, held in its normal position by the ligaments. The body of the axis can be seen to be displaced a little forwards. This forward movement of the body is checked, as in Lowson's case, by the locking of the odontoid process with the anterior arch

Case of Unilateral Rotatory Dislocation of the Atlas,

of the atlas and the transverse ligament.

with Fracture of the Anterior Arch.

J. L., æt. 21, fell off a horse on to his forehead. Beyond making him see stars, he was none the worse and got up and rode his horse home. He came up to St. Thomas's Hospital for advice on account of a stiff and painful neck. As rubbing and liniments after a fortnight had done no good, he was admitted.

On examination, it was seen that the patient carried his head a little flexed and turned to the right. movements were very limited and painful. Rotation of the head to the left side was practically abolished. The left transverse process of the atlas is easily palpable between the mastoid and the angle of the jaw. On the right side it cannot be felt, the finger sinking into a groove. Further palpation gives the impression that the process is displaced backwards. There is obviously a dislocation of the right side of the atlas. Just below and on the right side of the back of the neck there is a prominence of the middle cervical vertebræ, which is due to some accompanying rotation of the vertebræ below the injury. After a few minutes' standing the man becomes fatigued.

An examination made on a later day confirmed the above in all particulars, and it was further remarked that he could rotate his head to the right or injured side and not to the left or uninjured side. At first he was unable to open his mouth fully, so that it was impossible to make a full examination of his pharynx. His articulation was also thick and indistinct. was able to swallow what food he could get into his mouth. These disabilities slowly improved, so that when an examination of his pharynx was possible, the left transverse process of his atlas could be felt displaced forwards.

The skiagraph shows the unilateral dislocation of the atlas and the callus which has resulted from the fracture of the anterior arch of the same bone. As in all other skiagraphs it is practically impossible to be certain of the condition of the odontoid process. It was thought at the meeting of the Clinical Society at which this case was shown that it was not broken.

# SPECIAL REPORTS.

# GENERAL MEDICAL COUNCIL.

EIGHTY-NINTH SESSION

FIRST DAY.—Tuesday, May 25TH, 1909.

The President, SIR DONALD MACALISTER, in the Chair.

THE notification of the appointment of two members of the General Medical Council was read: (a) Frederick Taylor, M.D., F.R.C.P., M.R.C.S., as representative of the University of London for one year from February 24th, 1909; (b) David Neilson Knox, M.B., C.M., as representative of the Faculty of Physicians and Surgeons of Glasgow from May 3rd, 1909, to April 6th, 1911.

Dr. Taylor was introduced by Dr. Norman Moore, and Dr. Knox by Dr. Norman Walker.

The PRESIDENT then delivered his address. After referring to the early and mournful death of Dr. Lindsay Steven since the last session, and saying a few well-chosen words about his great worth as a physician, a teacher, and a philanthropist, he men-tioned that regrettable failures of health had led to the retirement of Dr. Pye-Smith and Professor Young, and spoke feelingly of the great help these gentlemen had afforded the Council on various occasions. He also reminded the Council of the great loss the profession had sustained in the death of Mr. Wheelhouse. He said, in continuation :-

The University of London has sent us a distinguished member of its Senate in the place of Dr. Pye-Smith, and the Faculty of Glasgow its Visitor in the place of Dr. Lindsay Steven. To Dr. Frederick Taylor and Dr. David Knox we offer the welcome which is due to their personal merits and services, no less than to their professional eminence. We may count with con-fidence on receiving from both the benefit of their

special knowledge and experience.

In accordance with my duty as President, it has fallen to me to make representations to the Government, through the Lord President of the Privy Council, on various matters regarding which resolutions were passed in November. The Council requested that steps should be taken for the appointment of a Royal Commission to inquire into the evil effects produced by the unrestricted practice of medicine and surgery by unqualified persons. The Lord President has decided to make preliminary inquiries on the subject, through the Local Government Board. A circular has accordingly been issued to Medical Officers of Health, asking for information concerning the extent of the practice complained of, and its effects on the general health, within their several districts. When the replies are received, the Lord President will be in a position to determine what further steps are desirable in the interests of the public.

From the Colonial Office the Executive Committee has received a copy of an Act of the General Assembly of New Zealand, entitled the Quackery Prevention Act, 1908. This Act is directed against obnoxious forms of irregular practice, and imposes heavy penalties for these offences. The Executive Committee have replied that they would welcome similar legislation applicable to other parts of the British Empire.

In the Tuberculosis (Ireland) Bill, as originally presented to Parliament, the duty of advising the Irish Local Government Board with reference to the application of the proposed law was assigned to the Irish Branch Council; but no provision was made for meeting the expenses the Branch Council must thereby incur. On discussing the question with the authorities, it appeared that no grant from public funds was likely to be made for the purpose. The situation was dealt with by transferring the duty in question to the Presidents of the Royal Colleges of Physicians and Surgeons in Ireland, and with this change the Bill has passed into law.

By the Bill for the Registration of Nurses, concerning which a communication was received from the Privy Council on November 13th, it was proposed to establish a General Nursing Council for the United Kingdom, of which one member out of sixteen was to be appointed by the General Medical Council. The Nursing Council was to frame rules inter alia "regulating, supervising, and restricting within due limits the practice of registered nurses." It was represented by you to be expedient that the Medical Council should stand in the same relation to the body concerned with nurses as it does to the Central Midwives Board. At the Privy Council Office note was taken of your views, and I have ground for believing that, should the Bill be proceeded with during the present session, it will be proposed to amend it in the sense you indicated, the Executive Committee being entrusted with the function which under the English Midwives Act is committed to the English Branch Council. Should this arrangement be sanctioned by law, the expense falling on the Council would be trifling, as the matters passing under the review of the Executive Committee could be dealt with at its ordinary meetings. unable to obtain any assurance that a subsidy from public moneys would be granted to the Council in respect of this public service. As, however, other proposals dealing with the registration of nurses are under consideration, and as opinion appears still to be divided on the general question, it is probable that legislation on the subject will be deferred.

By your direction I communicated the Council's resolution of November 28th respecting the General Anæsthetics Bill, 1908, to the Government Departments concerned. The resolution supported the proposal to restrict to qualified medical practitioners the administration of drugs with the object of producing unconsciousness during medical, surgical, or obstetrical operations. In the present session of Parliament another Bill having a similar purpose has been introduced. Both Bills propose that dentists registered after a certain date shall not be entitled to administer general anæsthetics unless they possess a medical qualification. On this particular proposal the Council did not pronounce an explicit opinion, though its resolution on the general principle involved might be held to indicate its views with sufficient clearness. Now, however, we are asked in various quarters to express an opinion on the point, and in particular to give an answer to a question bearing upon it, which is submitted on behalf of the Lord

President. The Council will therefore be called on to consider whether, apart from the saving to existing dentists of their customary practice, it is expedient in the public interest to confer in future on dentists who have no medical qualification, express legal authority to administer general anæsthetics to persons requiring dental operations. When it is kept in mind, first, that unless skilled attention is given to the state of the patient's bodily health no general anæsthetic is invariably "safe," and, secondly, that in dental practice the anæsthetist is often the operator also, it will be seen that the proposal contained in the Bills referred to is not without some justification in the interest of the public profection.

The Registrar has received replies from the licensing bodies to his inquiry as to the degree in which effect has been given to the Council's recommendation—that candidates for medical qualifications should be required to produce evidence of having received practical instruction in the administration of anæsthetics. Nearly all the licensing bodies have answered that this requirement is already or will in future be enforced. The Council is thus justified in its contention, that fresh legislation to this end, which to be effective must be penal in character, is neither expedient nor necessary at the present time.

With the assistance of the legal advisers, I have

With the assistance of the legal advisers, I have drawn up a memorandum on the penal procedure of the Council, showing the nature of the actions which have been held by it to constitute infamous conduct in a professional respect. This memorandum has been forwarded at his Lordship's own request, to the Secretary of State for the Colonies, and communicated by him to the Boards of Inquiry constituted by the medical enactments of the several Crown Colonies. It is to be hoped that the information conveyed will be useful in promoting uniformity of judicial action in professional matters within the Colonies concerned.

The penal cases to be considered during this session are not numerous, though some of them are grave. They include one in which it will be necessary to inquire into a charge of "covering" an unqualified assistant. That such charges have now become rare testifies to the efficiency of the action taken by the Council some years ago, and to the praiseworthy ambition of the profession to dissociate itself entirely from a practice which experience had shown to be liable to grave abuse. A few charges against dentists have come before the Dental Committee, who will report to the Council on the facts of each case. energies of the British Dental Association are actively engaged both in challenging what it deems to be reprehensible conduct on the part of registered practitioners of dentistry, and in applying with marked success a recent interpretation of the Dentists' Act to the suppression of unwarranted pretensions to professional skill put forward by unqualified persons. A judgment delivered in the Court of Appeal last week appears to limit the application of that interpretation. have asked our legal advisers to state for the information of the Council the precise nature of the

I am informed that, at the instance of the Association, an injunction for the restraint of dental practice by a company of unqualified persons has been granted by the High Court in England. This decision confirms the similar judgments of the High Courts in Ireland. But it is further held to impose on companies of unregistered practitioners the same disabilities as are now imposed on individual persons. Should this opinion be well-founded, the Act will prove even more effective than it has hitherto appeared to be for the prevention of irregular practice under cover of the Companies' Acts.

The active exercise of its judicial functions is obligatory on the Council, and the effects are, without doubt, salutary from the professional as well as from the public point of view. But these functions involve a heavy drain upon the Council's funds, and it is not easy to see how, under the present law, the drain can be obviated or moderated. Two recent cases, which were unusually prolonged, cost us in legal and other necessary expenses nearly £2,000. The result is that

the financial year closed with an aggregate deficit of over £650 in the accounts of three Branch Councils. Though the cases under the Dentists' Act were also both numerous and important, the simpler methods of investigation which the Act permits made the proceedings much less costly, with the result that the Dental Fund closed with a sufficient surplus to meet unforeseen emergencies.

It is fortunate that for each of the three preceding years the receipts of the Branch Councils exceeded their expenditure. Except, perhaps, in the case of the Itish Branch, the accumulated surpluses will enable them to meet the exceptional deficits of the present

Dr. Langley Browne has given notice of a motion that the proper steps be taken for adding to the Council a thirty-fifth member, to be elected by the practitioners of England and Wales. It will be for the Council, and afterwards for the Privy Council and for Parliament, to consider whether it is in fact expedient that the addition should now be made. In the near future we shall have an additional member from Ireland, as provided by the recent Universities Act; and we may also expect two additional members from the Universities of Wales and of Bristol. In coming to a decision on this question, it will be desirable to have regard, on the one hand, to the inelasticity of our finances, and of our Council Chamber, and on the other hand to the unity and efficiency of the Council as at present constituted. By the terms of the Medical Act, the question to be decided resolves itself simply into a question of "expediency." In other words, it is a question to be answered in the light of such practical considerations as I have ventured to recall to your attention, without seeking to prejudice your decision.

The Education Committee have had a further opportunity of reviewing the admirable digest of facts relating to the medical curriculum which was included in their report of last November. They will probably be prepared to offer to the Council certain definite conclusions, on which action may be taken if action is

required.

The Board of the Apothecaries' Hall of Dublin have informed the Registrar that they have determined to postpone until July 1st the resumption of their "Preliminary Examination in Education," concerning which the Council, on the recommendation of the Education Committee, expressed a strongly adverse opinion at its last meeting. The Executive Committee will report on the reply to this intimation which they deemed it their duty to forward to the Board. At a time when two newly-constituted teaching Universities, each with its own preliminary examinations, are in process of organisation in Ireland, it is difficult to perceive that any advantage to medical culture can arise from the proposed incursion of the Apothecaries' Hall into the sphere of general secondary education and examination.

The period for which the Council, on the applica-tion of the Apothecaries' Hall, appointed Sir Lambert Ormsby to act as an assistant examiner under the provisions of the Medical Act, 1886, will shortly expire. An application for a fresh appointment will be submitted to you on behalf of the Board. The Council will, I feel sure, recognise that Sir Lambert has discharged with efficiency the duties imposed upon him

by the Act.

The Executive Committee, in pursuance of the Council's instructions, have, with the assistance of our legal advisers, drafted a standing order applicable to cases of medical and dental practitioners who voluntarily apply for the removal of their names from the Medical or the Dentists' Register. Should this standing order be approved, it will provide for a casus omissus in the procedure of the Council, and remove a difficulty that has occasionally arisen.

On Saturday last we received from the Lord Pre-sident a copy of the draft charter prayed for by the British Medical Association, with a request for any observations the Council may have to make thereon. The draft charter proposes that certain powers, which are of a comprehensive character, shall be conferred on the Association. Some of the powers appear at first sight to trench on the statutory functions of the

Council, and these will require your careful consideration. It will probably be convenient that, in the first instance, the Executive Committee, in consultation with the legal advisers, should examine the draft charter, and report to you on the provisions that specially concern the Council.

Moved by Dr. LITTLE, seconded by Dr. NORMAN MOORE, and carried by acclamation: "That the President be thanked for his address, and requested to

let it be printed in the minutes."

Moved by Dr. NORMAN MOORE, seconded by Sir JOHN MOORE, and agreed to: "That the following constitute the Business Committee — Dr. Norman Moore, Chairman; Mr. Morris, the President, and Sir Christopher Nixon."

Moved by Dr. NORMAN MOORE, seconded by Mr. Thomson, and agreed to: "That the Council adjourn after 4 p.m. to enable certain committees to meet for

the completion of their reports."

Moved by Dr. McVail, seconded by Dr. Saundby, and agreed to: "That the following yearly tables be received and entered in the minutes

(a) I. and II. Tables showing results of Professional Medical Examinations during 1908.

(b) Table showing results of Professional Examinations for Qualifications in Sanitary Science, Public Health, or State Medicine during 1908.

(c) Table showing results of Professional Dental

Examinations during 1908.

(d) Table showing results of Preliminary Examinations during 1908.

(e) Answers sent by the medical authorities as to the exemptions granted by them in any part of their examinations during the year 1908.

(f) Table showing results of competition held in January, 1909, for Commissions in the Indian Medical Service.

Moved by Dr. McVail, seconded by Dr. Caton, and agreed to: That the thanks of the Council be conveyed to the Under-Secretary of State for India for the returns which he has again furnished to the Council, with the request that these returns may in the future continue to be furnished to the General Medical Council."

Moved by Dr. LANGLEY BROWNE, and seconded by Dr. McManus: "That representations be made to the Privy Council that it is expedient to confer on the registered practitioners, resident in England and Wales, the power of returning an additional member to the General Council."

After a short discussion, the motion was put, and the PRESIDENT announced that it had been carried by a majority of the members present: 17 for, 5 against,

8 did not vote, 3 absent.

Moved by Mr. Tomes, seconded by Mr. Morris, and carried: "That it be a further representation to the Privy Council that the addition in question be not made until the next ensuing general election of direct representatives."

Moved by Dr. Adve-Curran, and seconded by Dr. McManus: "That reports by Assistant Examiners in Surgery, of the Apothecaries' Hall of Ireland, be dis-

continued for the present."

After a discussion, the motion was lost: 5 for, 14

against, rr did not vote, 3 absent.

Moved by Dr. Adye-Curran, seconded by Dr.

McManus, and carried: "That Sir Thomas Myles, M.D., F.R.C.S.I., be appointed an Assistant Examiner in Surgery to the Apothecaries' Hall, Dublin, for a period of four years, in lieu of Sir Lambert Ormsby, who retires by rotation, his term having expired."

Moved by Dr. NORMAN MOORE, seconded by Mr. Thomson, and carried: "That the report by the Executive Committee on the proposed Preliminary Examination by the Apothecaries' Hall, Dublin, be received and entered in the minutes."

The report had reference to a letter received from the Secretary of the Apothecaries' Hall, Ireland, dealing with the postponement of the resumption of the Preliminary Examination in Arts till July 1st. 1909, after which date it will be revived. Dr. ADYE-CURRAN said this was a question of expediency, and not in opposition to the General Medical Council.

Moved by Dr. NORMAN MOORE, seconded by Mr.

MORRIS, and agreed to: "That the following report by the Executive Committee on the subject of voluntary withdrawal of names from the Medical Register and Dentists' Register, be received and entered in the minutes ":-

REPORT.

The Executive Committee having, on November 27th, 1908, presented to the General Council a report as to the course that should be followed in the case of voluntary applications from practitioners for the re-moval of their names from the Medical Register together with a proposed standing order, the General Council resolved that Mr. Lushington's opinion on the subject should be circulated amongst members, and that the further consideration of the report should be adjourned till the legal advisers had prepared a corresponding standing order with regard to dentists.

Mr. Lushington, as will be seen from the standing order, has now drafted regulations which will apply to both medical and dental practitioners.

"Standing Order, Chapter XIII., Rule 11.—Proposed new paragraph to precede the rest of the Rule:—

"Every application by a registered medical practitioner or dentist for the removal of his name at his own request from the Medical or Dentists! Persister own request from the Medical or Dentists' Register shall be accompanied by a statutory declaration, to be made by the applicant, that he is not aware of any proceedings or of any reason for the institution of any proceedings which might result in establishing cause for the erasure of his name from the Medical or Dentists' Register without his consent, or for depriving him without his consent of any qualification or licence entitling him to be registered.'

On motion from the CHAIR, it was resolved: "That the Council adopt the standing order which has been prepared by the Council's Legal Assessor, and recom-

mended by the Executive Committee."

Strangers then, by direction from the Chair, withdrew, in order that the Council might consider in camera an item in the programme of business.

The Council subsequently adjourned.

SECOND DAY.-WEDNESDAY, MAY 26TH, 1909.

The President, SIR DONALD MACALISTER, in the Chair.

The minutes of the last meeting were taken as read and confirmed.

The Council considered the case of Robert Kirk, The Council considered the case of Robert Kirk, formerly registered as of Delmynden, Carshalton, Surrey, but now of Willington, co. Durham, M.B., M.S., 1897, Univ. Glasgow, who had been summoned to appear before the Council on the following charge as formulated by the Council's solicitor: "That you abused your position as a medical man by committing adultary on various occasions with Lawre Sorth adultery on various occasions with Laura Sarah Hepple, the wife of Oliver Hepple, when you were professionally attending her and her children, Nellie, Ivy, and Olive Isabel. And that in relation thereto you have been guilty of infamous conduct in a professional respect.'

The complainant was Mr. Oliver Hepple.

Mr. Kirk was called, but did not answer to his notice, nor was he represented by counsel or solicitor. Mr. Oliver Hepple, the complainant, attended, accom-

panied by Mr. Hempson, his solicitor.
The Council's solicitor read the notice and a letter from Mr. Kirk, which had been received since the preparation of the documents and evidence. Mr. Hempson then addressed the Council on behalf of the complainant, and produced documentary evidence to show that Mr. Kirk had been in medical attendance on Mr. Hepple's family to a very recent date, which

He called Mr. Hepple as a witness, and examined him as to the accuracy of his declaration. Mr. Hepple

answered a question put to him by the Legal Assessor.

Strangers having been re-admitted after the Council had deliberated in camerá, the President announced the decision of the Council as follows:—

Mr. Hempson, I have to announce to you that the Council have judged Robert Kirk to have been guilty of infamous conduct in a professional respect, and have directed the Registrar to erase from the Medical Register the name of Robert Kirk.

The Council next considered the case, adjourned from May 27th, 1908, of Christopher Richard Kempster, registered as of Whitehall, Bank Place, Collins Street, Melbourne, Mem. R. Coll. Surg. Eng., 1896, Lic. R. Coll. Phys. London, 1896, who had been summoned to appear before the Ccuncil on the following charge, as formulated by the Council's solicitor:

"That you have accepted and continue to hold the appointment of Chief Surgeon to the Freeman and Wallace Electro-Medical Institute, of Melbourne and Sydney, Australia, a company which habitually seeks." to attract patients by the insertion in the Argus newspaper of advertisements of a scandalous, offensive and indecent nature, accompanied by a portrait of yourself and a statement of your qualifications, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants were the London and Counties-

Medical Protection Society, Limited.

Mr. Kempster was called, but did not answer to his-

The London and Counties Medical Protection Society, Limited, were represented by their Secretary, Dr. Hugh Woods.

The Council's solicitor having read the notice, Dr.

Hugh Woods opened the case on behalf of the complainants, and put in copies of the advertisements of which the Society complained.

which the society complained.

In the absence of the accused practitioner, the Council's solicitor read the letters of explanation which had been sent by Mr. Kempster.

After the Council had deliberated in camera, and

strangers having been re-admitted, the President announced the decision of the Council as follows:—

announced the decision of the Council as follows:—
Dr. Woods, I have to announce that the Council have adopted the following resolution:—
"That the Council do now judge Christopher Richard Kempster to have been guilty of infamous conduct in a professional respect, and do direct the Registrar to erase from the Medical Register the name of Christopher Richard Kempster."

The Council considered the sease of Christopher William

The Council considered the case of Charles William Brown, registered as of 7 Chorlton Road, Hulme, Manchester, M.B., Mast. Surg., 1889, Univ. Edin., who had been summoned to appear before the Council on the following charge, as formulated by the Council's solicitor:—"That you have employed as your assistant in connection with your professional practice a person not duly qualified or registered under the Medical Acts, namely, Mr. — Amery, and have knowingly allowed him on your behalf to attend and treat patients in respect of matters requiring pro-fessional discretion or skill, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainant was Mr. Thomas George Paterson. Mr. Brown attended in answer to his notice, accompanied by Mr. A. H. Bodkin, counsel, instructed by Mr. W. H. Martin, King Street, Cheapside, E.C. Mr. Paterson attended, accompanied by Mr. Alfred

Tarbolton, of Messrs. Brett, Hamerton and Tarbolton,

solicitors, of Manchester.

The Council's solicitor having read the notice, Mr. Podkin took a preliminary objection to such of the declarations as had not complied with the Ccuncil's Standing Orders as to time, and to which he had consequently not had adequate time to prepare

The President informed him that he would have an opportunity to object to any of these declarations as they were reached.

Mr. Tarbolton proceeded to address the Council in support of the complaint. The statutory declarations by Mrs. Marianne Simpson and Miss Jane Stewart Simpson, and the supplementary declaration by Mrs.

Simpson, were read and put in.

Simpson, were read and put in.

Mr. Tarbolton referred to the declarations by Mrs.

Emily Gertrude Pinder, Mrs. Elizabeth Lea Greenwood, and Miss Jessie Gower Taylor, and was proceding to refer to that of Mr. Edward Arthur
Burgess, M.R.C.S., L.S.A., when Mr. Bodkin took
objection on the ground that the declaration was dated
as recently as May 18th, 1909, and that, though he
had given notice to the complainant's solicitor to produce all essential witnesses, Mr. Burgess was not

present. The Legal Assessor advised that the declaration should be admitted, as the Council had no power to compel the attendance of witnesses, but that, in the absence of a witness counsel were allowed considerable freedom in dealing with his declaration.

Mr. Tarbolton called Mr. Thomas George Paterson

and Mrs. Marianne Simpson, and examined them as witnesses. They were cross-examined by Mr. Bodkin, and the latter answered questions put to her by the Legal Assessor and by a member of the Council, through the chair.

Mr. Tarbolton next called Miss Jane Stewart Simpson, and examined her as a witness. Mr. Bodkin did not cross-examine.

Mr. Tarbolton read the declaration by Miss Jessie Gower Taylor, Miss Elizabeth Lea Greenwood, Mrs. Emily Gertrude Pinder, and a supplemental declaration by the same witness, and Mrs. Sarah J. Holmes, Miss Agnes Kate Simpson, and Mr. Edward Arthur Burgess, M.R.C.S., L.S.A., all of which he put in.

This completed his evidence.

Mr. Bodkin called Dr. Thomas Arthur Helme and Dr. Arthur Wilson Chapman, J.P., as witnesses, and examined them as to Mr. Brown's professional and personal standing in Manchester.

The Council then adjourned.

# THIRD DAY .- THURSDAY, MAY 27TH, 1000.

The President, Sir DONALD MACALISTER, in the Chair.

The minutes of the last meeting were taken as read and confirmed.

The President announced that he had received from the Privy Council a copy of Bristol University Bill, which had passed its second reading in the House

of Lords, and that the following were the clauses

which affected the Council :-

7. The University is hereby empowered to hold qualifying examinations in medicine, surgery, and midwifery for the purpose of granting a diploma or diplomas conferring the right of registration under the Medical Acts as if the University had been a University in the United Kingdom legally qualified at the passing of the Medical Act, 1886, to grant diplomas in medicine and surgery, and

the provisions of Part 1 of that Act shall be read and have effect accordingly.

8. The Council of the University shall be entitled to choose one representative to be a member of the General Council constituted by the Medical Acts and Section 7 of the Medical Act, 1886, shall be read and have effect as if the University had been expressly included therein. Provided always that the fees for attendance and the travelling expenses of such member payable under Section 12 of the Medical Act, 1858, shall not be paid from the funds of the General Council or of the Branch Council for England until such time as upon the representation of the General Council or of the Privy Council made in the manner set forth in Sections 10 and 19 of the Medical Act, 1886, and subject to the provisions therein contained His Majesty may by Order in Council appoint.

The Council resumed the consideration, adjourned from Wednesday, May 26th, 1909, of the case of Charles William Brown.

Mr. Brown attended in answer to his notice, accompanied by Mr. A. H. Bodkin, counsel, instructed by Mr. W. H. Martin, solicitor, King Street, Cheapside, E.C.

Mr. Paterson attended, accompanied by Mr. Alfred Tarbolton, of Messrs. Brett, Hamerton and Tarbolton,

solicitors, of Manchester.

Mr. Tarbolton stated that in view of the objection which had yesterday been taken, on behalf of Mr. Brown, to the absence of certain witnesses, he had thought it his duty to telegraph to them to attend the Council on this day, and scught permission from the Council to call these witnesses.

Leave was accorded, and Mr. Tarbolton called Mrs. Emily Gertrude Pinder as a witness as to the facts to which she had deposed in her declarations. She was cross-examined by Mr. Bodkin, and re-examined by Mr. Tarbolton.

Mr. Tarbolton called Nurse Elizabeth Greenwood as a witness as to the facts to which she had deposed in her declaration. She was cross-examined by Mr. Bodkin, and re-examined by Mr. Tarbolton; she also answered questions put to her by the Legal Assessor.

Mr. Tarbolton next called Nurse Jessie Gower Taylor as a witness as to the facts to which she had deposed in her declaration. She was cross-examined by Mr. Bodkin, and re-examined by Mr. Tarbolton.

Mr. Bodkin then addressed the Council in a powerful speech on behalf of Mr. Brown.

He then called Mr. Charles William Brown as a witness on his own behalf, and examined him. Mr. Brown was cross-examined by Mr. Tarbolton, and re-examined by Mr. Bodkin. He also answered questions put to him by the Legal Assessor.

Mr. Bodkin called Mr. William Arkless Amery as witness, and examined him.

Mr. Amery was cross-examined by Mr. Tarbolton. On Mr. Bodkin intimating that he had two more witnesses to call, but on question put from the chair it was ascertained that the Council did not desire to hear any further evidence for the defence.

Mr. Tarbolton then addressed the Council in reply. After the Council had deliberated in camera, and strangers having been re-admitted, the President announced the judgment of the Council as follows:—
Mr. Charles William Brown: I have to announce

that the facts alleged against you in the notice of inquiry have not been proved to the satisfaction of the Council.

On motion by the Chairman of business, it was agreed that the Council should meet at 12 noon on Friday, May 28th.

The Council then adjourned.

# TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, MAY 14TH, 1909

The President, Dr. W. G. SMITH, in the Chair.

### EXHIBITS.

Drs. O'CARROLL and Purser exhibited a case of PROGRESSIVE BULBAR PARALYSIS

in a man, æt. 56. A year ago the patient first noticed a certain amount of difficulty in his speech. It was very indistinct, but still intelligible. He was now hardly able to protrude the tongue beyond the lips. He had a little difficulty in getting food back, but he did not complain of difficulty in swallowing, except occasionally with liquids. He complained of difficulty in the culty in holding his head up. There was a little wasting of the muscles of the thumb, and of the biceps and triceps of the right side. The knee-jerks of each side were sharp, and occasionally, on stroking the sole of the left foot, Babinski's sign was found.

They also exhibited a case which had been diagnosed as locomotor ataxy. The patient was a young man, act. 23, married at 19, the father of two healthy children. There had been no miscarriages. There was a distinct history of congenital syphilis. About a year ago he got suddenly weak in his left leg, with a pain in his knee. Since then he had had a progressive difficulty in walking. Some two years previously he had "seen double" for a short time. His present condition was that he had not got paralysis of any muscles, but had considerable difficulty in walking, and was very ataxic. Absence of knee-jerks. The pupils contracted neither to accommodation nor light. He appeared to have no loss of sensation in the limbs, but was rather slow in recognising touches on the left leg, especially from the knee down. He had a certain amount of difficulty in passing water; he often had to press, and sometimes it came away without sufficient warning. He had always been a little deaf.

DR. DRURY exhibited two cases of HEREDITARY ATAXIA

Sisters, æt. 11 and 13, who had the disease noticed about three and five years respectively. The younger was the much more advanced case. She stood fairly well with the feet apart, but could not balance at all with her eyes closed. The elder girl had sometimes a slight shaking of the hand, which was only noticeable when watching closely. There was no sensory disturbance, or disturbance of the sphincters. The eye-symptoms were variable. In the younger girl there was slight nystagmus, but some days it was absent altogether. In both cases there was a total loss of knee-jerks. The limbs were well nourished. The younger girl showed well-marked lateral curvature, and both feet were getting flat. She had a systolic murmur heard near the apex; and at the base of the heart she had a loud systolic murmur when lying down, which disappeared when she sat up. The day following the observation of the latter murmur it was exactly the reverse—that is, it was absent when lying down, and present when erect; it varied from day to Sisters, æt. 11 and 13, who had the disease noticed down, and present when erect; it varied from day to day. Her sister had the same. When they came to hospital they were very thin, but they had grown fatter, and better in colour after a couple of months on arsenic.

Dr. DRURY also exhibited a case of

Dr. Drury also exhibited a case of interpretation of the patient had not noticed anything peculiar about his condition, except that he was not a very powerful person. There was anything peculiar about his condition, except that he knew he was not a very powerful person. There was great thinness and want of muscle everywhere. There was no actual atrophy, but he took it that it was still in an early stage. Such cases were usually met with in groups, but there was no history of such in the in groups, but they was a sould not find anything present case. Although they could not find anything in the way of thoracic disease, still he had extremely marked myxædema. His grasp was feeble, but he had quite well-marked knee-jerks.

Dr. T. G. Moorhead read a paper on

GROCCO'S TRIANGLE,

giving his observations on the subject for some years

past.

Dr. KIRKPATRICK said he had looked for the sign during the past two years, and had endeavoured to demonstrate it. He could sometimes demonstrate it demonstrate it. He could sometimes demonstrate it to his own satisfaction, but he had often failed to do so to others looking on. It was in cases of small effusion that the sign was of particular value, and it was in such cases that it was very difficult to elicit it.

The President said that, short of post-mortem evidence, some mystification hung over the subject. It took ten ounces of fluid to produce recognisable physical signs, and in cases of large effusion the sign

was hardly necessary.

Dr. MOORHEAD, in reply, said he was an advocate of early removal of fluid, an dendeavoured to demonstrate it. In three of the five cases in which he did not get the sign he also demonstrated fluid, but he had not been able to demonstrate the relationship between the size of the triangle and the effusion.

Dr. Peacocke read a paper on a case of "Glioma of the Spinal Cord" in a girl, zet. 11.

# CORRESPONDENCE.

### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Mry 30th, 1909.

EPISTAXIS.

BLEEDING from the nose in certain persons, and especially the aged, is Nature's safety valve, and should be respected or at most controlled by gentle plugging; too brusque compression has been known to be followed by an attack of apoplexy, to which the patient succumbed.

It is however, frequently necessary, under other conditions, to have recourse to firm plugging of the offending nasal fossa in order to arrest the hæmor-

Many different methods have been practised to this end, all more or less disagreeable to the patient. Perhaps the most simple and the most effectual would be as follows:—A thin strip of absorbent wool about an inch and a-half wide is wound firmly two or three times around the point of a pencil or penholder; the pencil is withdrawn leaving a cone of wool about two inches long in the hand, and this plug is steeped in some hæmostatic solution (oxygen water, antipyrine, ferripyrine, etc.), or in pure water. The liquid swells the plug, which is then pressed firmly so as to flatten it as much as possible; it is still moist, long, flat, and a little stiff, of conical form, rendering it easy to pass into the nose. It is inserted horizontally, penetrating its entire length along the septum.

The free extremity of the plug is once more wetted an inch and a-half wide is wound firmly two or three

The free extremity of the plug is once more wetted with the hæmostatic solution, imbibing by capillarity the whole of the plug, which swells up, gently compressing the mucous membrane and effectually obstructing the orifice. A second small plug closes the aparture and the residual plug closes the aperture, and the patient is advised to hold his head slightly bent forward for about an hour to enable the blood to coagulate against the plug. After 24

hours the plug may be withdrawn.

According to Dr. Borde, these plugs seem to be well supported by the patients and produce no irritation of the mucous membrane.

#### TARSALGIA.

Pain in the heel, although by no means a rare affection, has been neglected by the majority of text-books, and yet it is very tenacious and rebellious to all medical treatment, and the patients suffering from this affection get discouraged and drag out a painful existence, for the infirmity, although presenting no external signs, deprives them almost completely of the power of locomotion, walking being so painful.

Vincent of Algiers recommended somewhat recently a very simple surgical treatment of the affection.

The ætiology of tarsalgia is somewhat varied: this malady, which may attack one foot, but more frequently the two feet, was noticed for the first time as far back as 1785 by Swediaur, who ascribed it to blennorrhagia, and in reality this is a frequent cause. Rheumatism, and sometimes gout, have produced it, and perhaps certain infectious diseases. But there is another cause which has been overlooked, viz., traumatism.

According to Dr. Vidal, tarsalgia may be divided into three classes: Inflammation of the serous bursa under the heel; osteitis of the os calcis, accompanied by hyperostosis.

In 13 cases observed by Jacquet, the presence of osteo-fibrous rheumatism of blennorrhagic origin with a certain degree of deformity of the bone was noticed.

Bonnet relates the case of a patient who suffered from excessive pain in the two heels after an attack of blennorrhagia. Radiography revealed the presence of a small bony excrescence under the aponeurosis of each heel.

The third class comprises a fibrous and neurotic form of tarsalgia without deformity which may be produced by the action of certain toxines secreted by infectious agents or by irritation provoked by chronic contusion, as might be observed in subjects whose profession or trade necessitates long standing, by which the adipose cushion of the heel is mechanically compressed or, still better, by a fall on the feet. It is in this last group that Vincent's operation succeeds.

A large incision is made down to the os calcis through the tissues of the heel, curettage of the fibro-adipose tissue suppressing the fibrous network in which the nerve filaments are strangulated; if the bursa is found to be inflamed, it is removed.

The second class seems to be amenable to medical

treatment: rest in bed, massage of the painful region. turpentine baths, ignipuncture down the back.

The turpentine bath recommended by Balzar is as

follows:-

Black soap emulsion and 6 oz.
Ess. of turpentine
However, if improvement was slow to manifest itself, an operation (curettage of the bone) should be tried.

CIRRHOSIS OF THE LIVER.

During the first period (hyperactivity) sedative treatment should be prescribed: Milk diet, laxatives (sulphate of soda, r dr., taken every morning for a week, in a glass of hot water); at night, cold compress wrung out, over the liver and covered with oil silk. Calomel in small doses, 1/5th gr., daily for eight days. The following eight days:—

Arseniate of soda, 1 gr. Water, 10 oz.

A tablespoonful twice a day.

At the period of atrophy, the milk may be replaced by feculents: potatoes with a little butter and salt, macaroni, meal of cereals, etc. Before each of the principal repasts a tablespoonful of:—

Iodide of potassium, 1 dr. Sulphate of strychnine, ½ gr. Water, 10 oz.

And

Benzoate of soda, 5 gr. Phosphate of soda, 10 gr. Jaborandi powder, 2 gr.

For one wafer; to be taken three hours after each

If ascites be present:-

Phosphate of soda, | āā 30 gr. Theobromin,

For three wafers, to be taken at an interval of one hour between each, and repeated during three days.

Vinegar of squills, digitalis or calomel in diuretic does might be tried.

doses might be tried :-

Calomel, 2 gr. Sugar, 10 gr.

For one powder, one to be taken every four hours, without exceeding, however, four in the day.

Such is the treatment advocated by Prof. Robin, of cirrhosis of the liver.

# GERMANY.

Berlin, May 30th, 1939.

AT the Verein für Innere Medizin, Hr. Heubner gave an address on

THE DIFFERENTIAL DIAGNOSIS OF THE ACUTE AND EXANTHEMATOUS DISEASES.

He laid stress on the importance of an exact diagnosis in the acute exanthematous diseases for the patient, for his immediate and his more remote surroundings,

and for the public.

As regarded differential diagnosis in the anteexanthematous stage, special difficulties were presented by those forms of disease in which a lengthened period of latency was a characteristic. Here there were irregularities in the stage of incubation, and even capable physicians were often led astray by them. It is true that these irregularities have been rendered less obscure by conclusions that have been drawn regarding the serum diseases, for which we are indebted to v. Pirquet. According to these conclusions the stage of incubation does not originate from the fact that the poison must first develop in the system, but for the reason that the antigen of the poison engages in a combat with the poison. This assumption is proved by the behaviour of the precipitins, the appearance of which corresponds with the outbreak of the disease, and which could not be proved to be present a short time before. According to this it is easy to understand that an early appearance of the exanthem corresponds with an earlier subjugation of the antigens by the poison. Bacterial examinations regarding streptococci in the prodromal stages of measles and scarlatina which the speaker had carried out had revealed nothing useful as to the differential diagnosis, as both in measles and scarlatina streptococci could be found, so that they could not be specific for both the diseases.

As regarded differential diagnosis in the exanthematous stage, there were the rare cases in which measles were mistaken for small-pox and vice versa. In measles there were occasionally large pock-like nodules, and an exanthem not unlike measles was also

seen in small-pox. Sometimes it was very difficult also to show the difference between measles and scarlatina.

Further, the exanthems of measles and scarlatina confounded with other exanthems. Here the morbilloid exanthems played a special rôle. especially those that appeared after taking certain medicines. From a point of view of differential diagnosis is here to be mentioned that on some part of the body or other an exquisite urticaria-like rash will be visible. The morbilloid exanthem of the infant at the breast causes a good deal of difficulty, even before the sixth month; as contrary to the general assumption that the infant is immune as regards exanthematous diseases before the sixth monthof life, we sometimes see them appear even in the earliest months. Finally, measles frequently appearswith a rash that has a rötheln character, and without the characteristic different mode of invasion.

Scarlatinoid rashes more rarely cause confusion. There is that which is called by some authors the 4th disease, a disease with a scarlatinoid rash and a course resembling rötheln. This disease is really not course resembling rothern. Inis disease is really not scarlatina, but a freak of rötheln. According to others there had been rötheln on to which scarlatina had developed, but there had been free desquamation previously. So much is determined: that rötheln not unfrequently runs a scarlatina-like course; and the different exanthems may sometimes be seen on different parts of the body at the same time. In a case recorded a patient is said to have had rötheln, and four weeks later developed the 4th disease. Against this is to be borne in mind that relapses of rötheln not unfrequently occur with an appearance different from the first attack. In any case the assumption of the 4th disease is not to be rejected until we know more.

And now still another, the 5th disease has made its appearance; it is described as allied to the two first diseases by an absolutely identical course, the so-called erythema infectiosum. It differs distinctly in the character of the rash, which in the face resembles erythema exudativum, whilst on the other parts of the body it has a scarlatina-like appearance. There is further to be pointed out the simultaneous appearance of two acute exanthematous diseases in one and the same child. Thus, according to Viennese authors, there is in measles a special disposition to scarlatina. The malignant scarlatina cases are said to be always cases of such mixed infection. (Pospischill.)

Scarlatina is also said to supervene on rötheln, and also on varicella. Finally, according to Viennese authors, scarlatina is liable to supervene on serum disease. Here it may certainly be observed that the distinction of the two exanthems is very difficult.

In vaccinia a measles-like rash is frequently seen. The diagnosis "generalised vaccinia" is often incorrect. The latter is wide spread over the whole body, easy to be distinguished from the varicella rash. We are far behind in exanthem diagnosis for the reason that we do not know the causal poison. The attempt to effect the complement separation by scarlatina antigen was successful—but unfortunately the same effect was brought about with measles. Perhaps the precipitine method will eventually show results.

# AUSTRIA.

Vienna, May 30th, 1909.

HÆMOPHILIA.

At the Gesellschaft der Aerzte Mautner showed a patient who had suffered for 4½ years with constant bleeding from the gums. This repeated bleeding commenced after the extraction of a molar tooth, and in spite of all efforts to check it would continue for threedays at a time. He obtained the normal serum of the horse from the Institute and injected 20 ctms., which immediately checked the hæmorrhage. The following day a slight oozing of blood appeared, when another 20 ctms. of the serum were injected. Since then no appearance of hæmorrhage has been observed, but on the 28th day after injection an erythema, re-sembling erythema multiforme, appeared over the

whole body. Teleky referred to Prof. Biedl's anaphylaxia by saying that the injection of the serum produced other changes in the organism, as he had found the blood after injecting animals lost its power of coagulation in the space of three weeks. He be-lieved the serum had the power of checking hæmor-rhage, but after three weeks the treatment would have to be repeated. Paltauf remarked that the loss of coagulation was only one phenomenon in anaphylaxia which Biedl and Kraus had observed in the dog, but the experiments were so few in the human subject that the therapeutic value of the serum was as yet very doubtful.

Goitre and Endemic Cretinism.

Kutchera, from Graz, gave the members an exhaustive account of the treatment of goftre and cretinism, which has been undertaken during the last two years by the State. This experiment was initiated by Prof. Wagner in 1907, in Styria, where the disease is endemic. This was conducted from 37 stations in the country, but the patients were treated in their own homes, free of charge, with 0.3 of a gramme in tabloid form; this has cost the Government 3,500 kronen. Treatment was commenced early and very few above the age of leaving school were treated, the eldest being 26 years. All cases of idiocy and the deaf and dumb were excluded, while the rachitic had phosphorus and cod-liver oil in addition. Each received one tabloid per day, but where they were badly borne, three in the week, with excellent results. In 1907 one hundred and eight thousand tabloids were used. In one year and a half 1,011 cases were treated, of these 761 in 1907, and the following year 250. Only 25 cases were unable to take the treatment. In 1908, 608 were still under treat-

Increase of growth in all the cases was very marked, and appeared to run parallel with the other symptoms, with the exception probably of the idiotic and deaf and with the exception probably of the idiotic and deaf and dumb, who increased in weight, but all the other symptoms remained stationary. The pure cretin is not an idiot, as his intelligence and hearing may be weak, but not destroyed. In 440 of the cases 10 per cent. rose to normal manhood; 18 or 4 per cent. slightly below this, while 377 or 85 per cent. rose above the normal. In 143 children below the age of 6 improvement was observed within a few weeks; the enlarged tongue, running of saliva, cutaneous secretion. larged tongue, running of saliva, cutaneous secretion, eczema, and the large gland were notably improved. At the beginning of the treatment it may be observed that a few of them diminished in weight and appeared to fall off, but after a short period there was rapid to fall off, but after a short period there was rapid improvement in the temperament, genitals, teeth, intelligence, speech and hearing. In 677 of the cases examined, 290 or 43 per cent. seemed to be in excellent condition, 329 or 48 per cent. were not so good, while 58 or 9 per cent. had made very slight improvement.

Hochsinger said his experiments were equally successful on the cretin and congenital myxedema. The

question remains: Shall it be necessary to continue the thyroid substance in congenital cases? Are our experiments too recent to give an opinion?

CANADA. Toronto, May 1909.

MEDICAL JOURNALISM IN CANADA.

Among the many problems engaging the medical profession in Canada at present, one of the most urgent is that relating to the medical press. The present state of first-named, any of these journals has any serious scientific standing. In fact, they are subscribed to partly on account of the local professional news they contain and partly for more personal reasons. As a consequence the clientèle of each journal is a very confined one, and no single one appeals to a very large

circle of readers. Indeed, it is probable that each of the three London weekly medical journals reaches an audience considerably more extensive than any Canadian journal. There is, it will be noticed, no Canadian weekly medical journal in existence. This lack has been keenly felt of late years, and an active body of physicians, prominent among whom is Dr. McPhedran, of Toronto, have made many attempts to remedy it. The most obvious course would seem to establish a journal under the auspices of the Canadian Medical Association, and this body has actually agreed

There are, however, more difficulties in the way than might at first sight appear. First is the question of support. It is gravely doubted whether a sufficient number of practitioners would subscribe to either the Association or to the journal directly to ensure the financial success of the venture. The distances separating the different parts of Canada are so large that the interests in common between Quebec Winnipeg, for instance, are very slight, especially as mutual reciprocity between the provinces is so restricted. Therefore, for local medical news each district prefers to rely on its local journal, and for scientific literature on British or American publications. In the next place it is doubtful whether there is enough material to fill such a journal. The great majority of medical men in Canada, even in the large centres, are engaged in general practice, and the number of those who undertake any scientific research or who make original observations is very few. As a result the output of scientific work in medicine is strikingly small, and such as it is is sent to British, or more often to American journals. This state of affairs is, of course, likely to alter as the country gets more settled and developed, but such changes take place slowly. Still, the advent of a weekly Canadian medical journal cannot be long delayed, and it may be expected within a very few years at the longest.

CANADIAN MEDICAL SOCIETIES.

In the matter of medical societies, Canada is more happily placed. Besides the Canadian Medical Association, which holds an annual meeting on the lines of that of the British Medical Association, several of the provinces have an association, which also meets once a year. There are a considerable number of medical societies in the smaller towns, as Halifax, Quebec and Hamilton. One has recently been established. Mished in Winnipeg, with three sub-sections. The Montreal Medical and Surgical Society has for many years been noted for its activities. The Ontario Academy of Medicine is perhaps the most ambitious. It owes its inception largely to the stimulus of Professor Osler, who on several occasions advocated the merging of the local societies into one Academy, as has been done in London to form the Royal Society of Medicine. This was finally accomplished a year ago, and the Academy took possession of the building in and the Academy took possession of the building in Toronto, formerly occupied by the Ontario Medical Library Association. There the nucleus of a good library has been begun, though it is confined almost entirely to books and journals in the English language. The Academy has six sections, one each for Medicine, Surgery, Pediatrics, State Medicine, and Gynæcology, and one for Ophthalmology, Rhinology, Otology and and one for Ophthalmology, Rhinology, Otology and Laryngology. Each section meets, as a rule, once a month, when cases are shown, papers are read, and demonstrations given. Once a month, also, a general meeting is held, at which an address is given by some distinguished visitor, usually American. The meetings are held at the rooms of the Academy in Queen's Park, except the Pediatric meetings, which, for the sake of convenience, take place in the Children's Hospital. The Ontario Medical Association meets this present a Toronto from June 1st to 2rd. At the final year at Toronto from June 1st to 3rd. At the final stance Professor Osler, who is now on a visit to this Continent, is to read an address.

THE CANADIAN MEDICAL CURRICULUM. There is at present much activity in Ontario in connection with the reorganisation of the medical curriculum in the University of Toronto. Since the appointment last December of Dr. C. K. Clarke as Dean of the Medical Faculty a great deal has been

accomplished, and it is certain that in the future the

training at this University will be greatly improved, so that it will achieve a higher scientific standing than has hitherto been the case. The re-building scheme of the General Hospital has been taken up afresh, the connections between the Hospital and University have been made more intimate and perhaps more cordial than before, and a general plan has been outlined and practically accepted for future working. There is every hope that the new hospital may begin building in the coming fall, and an excellent site near to the University has been secured. It is rumoured that Dr. Cecil Leathes, of London, has accepted a professorial position here, and that he will take up his duties in the coming session.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

### SCOTLAND.

CRIGHTON ROYAL INSTITUTION, DUMFRIES .- The sixty-ninth annual report of this asylum has lately sixty-ninth annual report of this asylum has lately been issued; it is of interest as being the first from the pen of Dr. Easterbrook, the newly-appointed Physician Superintendent. The total number of cases under treatment during 1908 was 1,034, the average daily in residence being 852—an increase of 32 over the preceding year. The death-rate was low, 6.4 per cent. of the average resident population; nearly half the deaths were due to brain disorders, and only 9 per cent. to pulmonary tuberculosis. The ratio of insanity to the population of Dumfries and Galloway is, according to the 45th Lunacy Blue-Book for Scotis, according to the 45th Lunacy Blue-Book for Scot-land, slightly above the average. Investigation of the causes of the mental breakdown among the patients admitted showed that the constant factor is a nervous constitution, inherited or acquired, and that the so-called exciting causes of insanity—worry, shock, illness, overwork, alcoholism, etc.—are accidental factors, inasmuch as they are insufficient to light up an attack in those with stable nervous systems. In Dr. Easterbrook's experience no person becomes of unsound mind without previously exhibiting evidence of an unduly nervous constitution, inherited or acquired. This evidence may be derived from the occurrence of morbid nervous or mental manipulations among the relatives of the patient, or, more important, from the patient himself, as afforded by the signs of a nervous physique or physiognomy, by the existence of some congenital nervous or mental defect, or by the occurrence of some neurosis or psychosis during former life, or by previous addiction to excesses, or by the possession of an abnormal or a typical disposition and temperament. The last is, in Dr. Easterbrook's experience, the most frequent as well as the most delicate or subtle sign of an unstable nervous system.

During the year the sanatorium was fully occupied, and every advantage was taken of it for extending the sanatorium treatment to all forms of mental affection. Many improvements have been effected during the year—verandahs have been added to the hospital wards, fresh precautions against fires have been taken, an additional villa residence for private patients has been provided, and the accommodation for the patients belonging to the lower private and parochial departments has been improved. The principal change which Dr. Easterbrook has inaugurated is in the direction of developing the pathological department. A thoroughly equipped laboratory for clinical and scientific research is being looked forward to with the greatest interest by the medical staff, and will help the latter still more than hitherto in the diagnosis and treatment of the patients' maladies. As the success of the laboratory depends not so much on the walls and appliances as on the efforts of its workers, the highly important question of the personnel of the Crighton laboratory staff is still under consideration. Appended to the report are the reports of the Commissioners on Lunacy, which testify to the excellence of the management of the Asylum.

Since Dr. Easterbrook's report was issued arrange-

ments have been made for the appointment of Research scholars to work in the new laboratory. The scholar-ships are worth £250 a year, and may be renewed. Applicants must have shown their competence to do research, and have had training in the necessary methods.

# LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

THE CAMPAIGN AGAINST UNOUALIFIED DENTISTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—It is much to be deplored that Dr. Duke should have published the letter under the above heading which appears in your issue of May 26th. If Dr. Duke were an obscure and unknown man, the mischief would be less. He seems not to have realised that his letter is as good an argument against medical law reform for which you are striving as it is against prevention of practice of dentistry by men falsely pre-tending to be qualified. The fitting of artificial teeth is very rarely a purely mechanical operation. There are always questions of surgery of remaining teeth to be considered; and, however skilful be the mechanic, he cannot help inflicting unnecessary suffering and injury if he have not at least the knowledge of surgery that is called for in the licentiate in dental surgery. The injury that an ignorant practitioner of dentistry must inflict in a large proportion of cases renders a minimum qualification essential. What would Dr. Duke say if it were argued that some surgical instru-ment makers were skilful, and could adapt and apply a pessary with a success equal to or greater than the qualified specialist. No law will ever be passed to prevent artificial teeth-makers from carrying on their trade, and no law will ever be made to prevent un-qualified men from practising in any other department of medicine or surgery, so long as they do not falsely pretend to be qualified. The public are guarded against such deception in the case of lawyers, dentists, and veterinary surgeons, but not in the case of doctors. For this reform you, Sir, are now working. Dr. Duke's letter and utterances of that kind cannot be said to be helpful to the cause.

I am, Sir, yours truly,
M.R.C.S., L.D.S.

May 26th, 1909.
[Dentistry does not directly involve questions of life and death, but the issues it includes are sufficiently serious. If Dr. Duke will inquire he will find that there are vast numbers of people, especially among the less wealthy classes, who are going about with mouths to the last degree septic owing to the fact that artificial teeth have been fixed in over a mass of necrosed and suppurating roots by ignorant or dishonest artificial teeth makers. The trade of the bone-setter, which Dr Duke wishes put an end to, is not much more harmful than this, and practically does not involve so great a risk to life. Septic mouth of the kind I refer to is in itself a cause of mortal disease, and constitutes a determining factor in bringing about a deadly result in many maladies which otherwise might be made amenable to treatment.]

MEDICAL RESEARCH DEFENCE SOCIETY. To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-The Committee of the Research Defence Society have asked me to send you a copy of a letter which has been sent to the Secretary of State for Home Affairs, as follows:

To the Rt. Hon. Herbert J. Gladstone. Sir,-We desire, as members of the Research Defence Society, to call your attention to the fol-

lowing facts:

The Royal Commission on Experiments on Animals was appointed in 1906. It began to hear evidence in October of that year, and during 1906 and 1907 a great amount of evidence was given by many witnesses. So long ago as December 18th, 1907, the Commissioners decided that they did not

wish for any further evidence, but they met once more, on March 25th, 1908, to hear evidence on a special point. Apart from this one meeting in 1908, it is now nearly a year and a half since the Commissioners ceased to hear evidence, but they have not yet issued their report.

We are of opinion that this long delay is con-

trary to the public interest, and is likely to pre-judice the public mind. We, therefore, beg you to exercise all your influence to hasten the issue

of the Report.

We remain, Sir, yours faithfully, The letter has been signed by the Earl of Cromer, President of the Society; the Hon. Sydney Holland, Chairman of Committee; the Duke of Abercorn, Lord Avebury, Lady Bliss, Lord Robert Cecil, Lord Cheylesmore, Sir Savile Crossley, the Hon. Walter Guinness, Sir Edwin Ray Lankester, Sir Frank Lascelles, Mr. Frederick Macmillan, the Earl of Malmesbury, Sir Patrick Manson, the Duke of Montrose, the Dean of St. Patrick's, Lord Rothschild, Mrs. Scharlieb, Professor Starling, Sir Reginald Talbot, Sir Frederick Treves, the Duke of Wellington, and the Bishop of Winchester.

I am, Sir, yours truly, STEPHEN PAGET,
Hon. Sec. Research Defence Society.

70 Harley Street, W., May 26th, 1909. The letter has been signed by the Earl of Cromer,

# AUSTRALIA FOR THE SONS OF MEDICAL MEN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—Some time ago you were good enough to allow me to call attention in your columns to the opportuni-ties which life on the land in Australia offered to lads and young men, and to point out what excellent avenues to this the various Government Agricultural training in scientific and practical agriculture in all its branches can be obtained at a cost of from £20 to £30

a year, including first-class board and lodging.

After finishing the course, fertile land in a district
of good rainfall can be obtained on reasonable terms, for either sheep, wheat, dairying, fruit growing, or mixed farming. As a result of this many doctors mixed farming. wrote to me, and some have already sent out their

I am at present in London, and will be glad to correspond with any others, or arrange an interview with them.

I have visited most of these colleges myself, and so can speak from experience. I hope to make arrangements for a lantern lecture on the Australian Agricultural Colleges, to be given at Belfast when the British Medical Association is meeting there, and to be present myself, to see any medical men who may desire further information.

My address for the next two months will be the Royal Colonial Institute, Northumberland Avenue, London.

I am, Sir, yours truly, RICHARD ARTHUR, M.D., President, Immigration League of Australasia.

AN URGENT APPEAL FOR ASSISTANCE. To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—May I ask you courteously to publish the accompanying list of donations in answer to the "appeal" which you kindly inserted in The Medical Press and Circular " for May 19th, 1909?

I am, Sir, yours truly, John W. Moore.

Sir Charles A. Cameron, C.B., Dublin Dr. Ninian Falkiner, Dublin Dr. Charles Gibbs, London "Anonymous" (University of Leeds) John Brown, Esq., M.D., D.P.H., Bacu C. E. Cormack, Esq., M.D., Villa d'Als	  p	I 2 2 0	2	0
Vichy Postal Order, Devonshire Street, London,	w.	I	0	0
"A Well-wisher," Boscombe, Bournemo Hants "Anon," Exeter	• • •		0	
Sir John Moore, M.D., Dublin Dr. Ninian Falkiner, Dublin Dr. Maguire Sir Stewart Woodhouse, M.D., Dublin		<b>2</b> 0	2 2 10 3	6

# **OBITUARY.**

CHARLOTTE LOUISA ELLABY, M.D.PARIS, L.S.A.

WE regret to announce the death of Miss Charlotte Louisa Ellaby at her house in Harley Street, at the

age of 55

Miss Ellaby graduated M.D. in Paris in 1884, and in the autumn of that year, on the recommendation of Mrs. Garrett Anderson, she went out to Bombay to join Dr. Edith Pechey (the late Mrs. Pechey-Phipson), first at a temporary hospital, and afterwards as second physician to the Cama Hospital for Women and Children on the opening of the institution in 1886. Here Miss Ellaby worked most successfully, not only in the special eye department which she inaugurated,

but also in a very large out-patient department.

After some years of this work in Bombay Miss Ellaby resigned her appointment and returned to this country for the purpose of devoting herself entirely to ophthalmology. In order to have a registrable British qualification she passed the examination of the Society. of Apothecaries, which had recently been reopened to women. In 1900 she accepted an invitation of the committee of the New Hospital for Women to organise an eye department there, and was appointed the first ophthalmic surgeon. Here she worked until failing health, fought with great courage, compelled her resignation three years ago. In the winter of 1894-5 Miss Ellaby had returned to India for a few weeks to perform a double-cataract operation upon the Ranee perform a double-cataract operation upon the Ranee of Jamnagar. The operation was successful; but it was partly to this visit to India that Miss Ellaby attributed her subsequent ill-health. At the time of her death she was consulting ophthalmic surgeon to the New Hospital for Women, lecturer on ophthalmic surgery to the London School of Medicine for Women, and a member of the Faculty of Medicine of the University of London the University of London.

# THOMAS FREDERICK HOPGOOD, M.R.C.S., L.R.C.P.

WE regret to record the death of Dr. Thos. Frederick Hopgood, of Sunderland. Dr. Hopgood had a stroke last July, but had seemingly recovered from the effects of it. He had reached the age of 62.

Perhaps the chief work of the deceased was associated with the Sunderland and Durham County Eye Infirmary, to which patients from all parts of the North of England went to be treated. He practically founded the present institution, and his enthusiasm Infirmary work also occupied much of the time and skill of Dr. Hopgood, and he was there on the day prior to his death, to all appearance as well as usual. Dr. Hopgood studied at University College, London, was a Fellowes gold medallist and silver medallist in surgery, medical jurisprudence, and pathological anatomy.

# OPERATING THEATRES.

# ST. THOMAS'S HOSPITAL.

PYOSALPINE AND GENERAL PERITONITIS. - MR. EDRED CORNER operated on a woman, æt. 32, who had been admitted for severe abdominal pain and vomiting, which had come on a fortnight previously, after a long walk. She had worn a ring pessary for years, and her menstruation had been very irregular. On admission the abdomen was found to be soft, but there was great tenderness in the lower part. There was an indefinite swelling in the left iliac region. The operation was performed on the fifth day after admission. The temperature was subnormal and the pulse 72.

An incision was made in the middle line. The intestines were found to be red and injected. A double pyosalpinx was present, and on the left side there was pyosaipini, was present, and on the left was also a cyst containing foul-smelling pus. Both tubes were removed, the broad ligaments ligatured, and Douglas's pouch drained per vaginam and by the abdomen. The appendix was also removed as it was included in the adhesions; it was the seat of considerable inflammation, which, Mr. Corner remarked, was secondary to the salpingitis.

Mr. Corner said the diagnosis of the case had originally been that of acute peritonitis, but when the patient was examined per vaginam a large pyosalpinx was easily felt on each side. The uterus was fixed by the adhesions. He pointed out that it was always more difficult to separate a pyosalpinx on the left side owing to the adhesions between it and the rectum, adhesions which seem almost to surround the gut; the separation is much less difficult on the right side, where, however, the surgeon has sometimes to deal with the appendix, as in the present case, in which he considered the safer plan was to remove the

appendix, which was much inflamed. The after history of the case was peculiar; there was subsequently a free discharge through the vagina and from the abdominal wound. Fever continued for nearly seven weeks, with cough and expectoration. No bacilli of tuberculosis were found in the sputum. There was dulness at the bases of the lungs; aspiration was negative. The patient ultimately recovered.

Mr. Corner considered that the infection must have travelled from the pelvis by the ascending colon to above the liver, between it and the diaphragm, giving rise to a sub-diaphragmatic abscess, which had discharged through the lung. This infection, he thought, must evidently have travelled up before the operation for pyosalpinx. There had been no suspicion of it at the time.

#### News in Brief. MEDICAL

Prevalence of Measles.

MEASLES still continues to cause a number of deaths. In the 76 large towns to which the official returns In the 76 large towns to which the official returns relate the general death-rate last week was 14.7 per 1,000, having in the previous three weeks been 14.5, 14.1, and 13.7. In some towns, however, the rate was much higher, i.e., West Bromwich, 21.5; Tynemouth, 22.4; Coventry, 23.4; Wolverhampton, 28.9. Wolverhampton's death-rate from measles alone was 6.5, and Coventry's 2.6 from the same cause. Two deaths from small-pox were registered in Bristol. London's death-rate from all causes was 14.0 per 1 000, including 52 rate from all causes was 14.0 per 1,000, including 53 deaths from measles.

International Congress of Applied Chemistry.

THE seventh International Congress of Applied Chemistry was opened on May 27th at the Albert Hall by the Prince of Wales. Over two thousand scientists by the Frince of wales. Over two thousand scientists were present, including a number of lady chemists from Russia and America. Germany is represented by Professor O. N. Witt, of Charlottenbourg, Dr. Delbrück, Dr. Dinsberg, and others; France by M. Gautier, M. Sabatier, and M. Béhal; and delegates came not only from every European country, but even came not only from every European country, but even from China and Japan. In the evening the Lord from China and Japan. In the evening the Lord Mayor entertained Sir William Ramsay, the President, and the various delegates at the Mansion House. The Ambassadors of the foreign countries represented at the Congress and the members of the Government were invited. Afterwards a reception was given to the delegates at the Foreign Office by Mr. Lewis Harcourt, on behalf of the Government.

#### Death Under Anæsthetics.

THE circumstances surrounding the death of George John Cornish, aged 66 years, were investigated on May 17th by Mr. P. H. Childs, Deputy Coroner for Portsmouth. The widow, Catherine Cornish, stated that her husband had been under operations at the hospital for cancer. He had not been able to take solid food since August. On the 14th inst. deceased was prepared for an operation at the hospital, and when a couple of drops of chloroform had been administered to him by Dr. Pope deceased expired before the actual operation was commenced.

Deceased had previously been examined according to the rule. Artificial respiration was resorted to for half an hour, but without avail. Dr. Pope had made a post-mortem examination, and attributed death to syncope. The Deputy Coroner remarked that the jury had received

evidence that the operation was necessary, and he was satisfied that the anæsthetic had been given in a competent manner. The jury returned a verdict in accordance with the medical evidence, and the foreman remarked that the jury were satisfied that the anæsthetic had been properly given.

#### Medical Examination of School Children in Fife.

THE sub-committee appointed by the Fife County Council to meet the County Education Committee in connection with the scheme for the medical examina-tion and supervision of school children met in the County Hall, Cupar, on May 21st, Sir Ralph Anstruther, Bart., presiding. It was pointed out that while the County Council

had practically given consent to Dr. Dewar, the county medical officer, being the responsible officer for carrying out the scheme, Dr. Dewar was also the medical officer for the District, and that the District Committees would have to be approached on the subject.

Mr. Wm. Low stated that they would make the necessary representation to the District Committees, and he submitted a memo. on the subject, showing what quid pro quo they proposed for Dr. Dewar's services.

Before finally agreeing to the terms of appointment the secretary was instructed to communicate with ex-Provost Alexander on the subject.

Commemoration Day.-Proceedings at Livingstone Col-

COMMEMORATION Day, on Wednesday last, drew a very large and influential company to the College at Leyton.

The Very Rev. Dr. Butler, Master of Trinity College, Cambridge, presided, and the Principal, Dr. C. F. Harford, made an introductory statement showing the great progress which had taken place since Professor Macalister gave the inaugural address in the first premises of Livingstone College 15 years ago. Public opinion had entirely changed as to the necessity of medical training for missionaries, and it was now regarded as an absolute necessity for missionaries to have some medical knowledge.

The Master of Trinity, in his address, referred to Ine Master of Trinity, in his address, referred to Livingstone's challenge to Cambridge University, in which he said: "I go to Africa to make an open door for commerce and Christianity; do you carry out the work which I have begun, I leave it with you." This challenge has led to the going forth of Bishop Mackenzie and others who had sacrificed their lives in the cause of civilisation, these valuable lives might have been saved if they had had the advantage of modern training such as was given at Livingstone College.

Dr. Alexander Macalister, after referring in very kind words to the Principal, who had been one of his old pupils at Cambridge, stated that he had watched the College with great interest, from its commencement, and though doubts had been expressed as to the wisdom of the training given, he thought that these wisdom of the training given, he thought that these doubts had long since been laid aside, and as an old medical teacher he had thorough confidence in the course of training given at the College. From his experience in many parts of the world, specially in Syria and in China, he believed that it was a necessity for a missionary to be able to render simple medical aid to the natives, and in the absence of qualified medical aid it was most important that ordinary missionaries should have elementary medical training as is given at Livingstone College. He hoped that before long some such training would be regarded as an absolute neces-

br. Stein, the well-known Asian explorer, related how he had consulted many eminent surgeons both in India and in England, and they all said that nothing could have been better than the conservative surgery which had been carried out by Mr. Schmitt, and which had left him far greater use of his right foot than he

had ever ventured to expect.

Mr. W. McAdan Eccles, F.R.C.S., moved a hearty vote of thanks to the chairman and speakers, which was seconded by Dr. Price. The meeting terminated with the Benediction, which was pronounced by the

Master of Trinity.

#### NOTICES TO CORRESPONDENTS. &c.

Correspondents requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two valumes each year begin on January lat and July 1st respectively. Terms per annum, 21s.; post free at home cr abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12. Messrs. Dawson and Sons are our special agents for Canada.

ADVERTISEMENTS.

ADVERTISEMENTS.

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ORIGINAL ARTICLES OR LETTERS intended for publication abould be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

CONTENUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Dr. Leslik Thorne Thorne's letter is unavoidably held over

DR. LESLIE TRORKE TRORKE'S letter is unavoidably held over until our next.

COL. F. H.—Owing to the closure of the office on Bank-holiday, your "Notes" were received too late for insertion in the present

COL. F. H.—Owing to the closure of the office on Bank-holiday, your "Notes" were received too late for insertion in the present number.

DR. HARDY.—The work is by an American author, and is published in New York.

EXCELEGIOS.—As has been repeatedly pointed out in our columns, the term "ophthalmia" has no scientific significance, and is now obsolete. Iritis, of rheumatic origin, which formerly was called rheumatic "ophthalmia," is now called rheumatic iritis, and, similarly, "purulent conjunctivitis," in childhood, has displaced the antiquated term "ophthalmia neonatorum."

L.R.C.P. (Manchester).—The case was tried in the High Court in February and dismissed. Yours would appear to run on parallel lines, and we should advise you to leave law alone.

DR. J. Russell. will find a detailed account of the arrangements, hotel and lodging accommodation at the forthcoming Congress at Buda Pesth in our issue for April 28th.

H. G. N. (Sunderland).—Your experience is by no means novel, we have often pointed out that the proper course, if consulted upon a case in which civil proceedings are contemplated, the amount of fees for examination, and for appearance in court on first and subsequent days, should be clearly set forth and agreed upon. Further, we advise that unless the solicitors and their clients are men of the best reputation, it is well to insist upon fees being paid before taking any further action—at any rate, before going into the witness-box. Crede experto.

W. A. S.—Tar preparations have been to a great extent superseded by more elegant remedies, such as oil of cade, creolin, and oyllin. Some day, however, it is possible that the virtue of homely tar as an external remedy may be rediscovered. It is diuretic and mildly antiseptic, and is sometimes useful in gastro-intestinal catarrh. At one period tar water enjoyed an enormous vogue as a specific for a host of maladies—in France it was the famous Eau de Goudron.

Scotties Practitioner.—Yes, you may do so, provided you have the necessary ever for the reception o

#### Meetings of the Societies, Tectures, &c.

WEDNESDAY, JUNE 2ND.

MEDICAL GRADUATES COLLEGE AND POLICLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. E. Corner: Clinique (Surgical). 5.15 p.m. Lecture:—Dr. C. Mercier: On the Diagnosis of General Paralysis in its Early Stage.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

THURSDAY, JUNE 3RD.

NORTH-EAST LONDON CLINICAL SOCIETY (Prince of Wales's

THURBDAT, JUNE SED.

NORTH-EAST LONDON CLINICAL SCIENT (Prince of Wales's Hospital, Tottenham, N.).—415 p.m.: Election of Officers for 1809-10. Clinical Cases.

MEDICAL GRADUATES' COLLEGE AND POLICLINIC (22 Chenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture:—Dr. E. Wynter: Treatment of Chores

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynscolegical Operations (Dr. A. E. Giles). Clinics: Medical Out-petient

CDr. A. J. Whiting); Surgical (Mr. H. W. Carson); X.Rays. 3 p.m.: Medical In-patient (Dr. G. P. Chappel).

FRIDAT, JUNE 47H.

WEST LONDON MEDICO-CHIERRICAL SOCIETY (West London Hospital, Hammersmith Road, W.).—8.30 p.m.: Mr. C. Ryall will open a Discussion on Spinal Ansesthesia and will illustrate his latest method with diagrams.

MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Chenica Street, W.C.).—4 p.m.: Mr. H. Barwell: Clinique (Ear, Nose, and Throat).

NORTH-EAST LONDON POST GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. E. M. Leslie).

#### Appointments.

JOHNSON, R. FITZHERBERT, M.B., Ch.B.Edin., Junior House Surgeon at the North Staffordshire Infirmary and Eye Hospital.

Liddell, L. S. L., M.B., M.S.Edin., Medical Officer and Public Vaccinator for the Bury Relief District of the Rugby Union.

Pollock, W. B. Inglis, M.D.Glasg., Assistant Surgeon to the Glasgow Eye Infirmary.

#### Bacancies.

Royal South Hants and Southampton Hospital.—House Physician.
Salary £100 per annum, with rooms, board, and washing.
Applications to T. A. Fisher Hall, Secretary.
North Devon Infirmary, Barnstaple, Devon.—House Surgeon.
Salary £100 per annum, with board, residence, and washing.
Applications to Chairman, House Committee.
Ring Edward VII. Sanatorium, Midhurst, Sussex.—Senior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19 Dovonshire Street, Fortland Place, London, W.
Finsbury Borough Council.—Medical Officer of Health. Salary, £500 per annum. Applications to G. W. Preston, Town Clerk, the Town Hall, Rosebery Avenue, £C.
Sheffield Union Hospital.—Assistant Medical Officer. Salary £100 per annum, with apartments, rations, and the other usual allowances. Applications to Albert Edwd. Booker, Clerk to the Guardians, Union Offices, Westbar, Sheffield.
Leeds General Infirmary.—Resident Surgical Officer. Salary £150 per annum, with board, residence, and washing. Applications to the Secretary of the Faculty, at the Infirmary.
Norfolk County Asylum, Thorpe, Norwich.—Second Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, attendance, and laundry. Applications to the Medical Superintendent.
The Hospital for Sick Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer. Salary £30 for six months, washing allowance £2 10s., with board and residence in the Hospital. Applications to the Secretary. (See advt.)

8t. Mary's Hospital, London, W.—Resident Assistant Amethetist, Salary £100 per annum, with board and residence. Applications to Thomas Ryan, Secretary.

Wys House, Asylum, Buxton.—Assistant Medical Officer. Salary £120 per annum, with board and residence, and laundry. Applications to the Medical Superintendent.

Royal Surrey County Hospital, Guildford.—House Surgeon.

Superintendent.

oyal Surrey County Hospital, Guildford.—House Surgeon.
£100 per annum, with board, residence, and laundry. Applications to the Hon. Secretary at the Hospital.

oroseter General Infirmary.—House Physician. Salary £100 per annum, with board, residence, and washing. Applications to William Stallard. Secretary, Worcester Chambers, Pierpoint Street, Worcester.

#### Births.

BORIN.-On May 23rd, at Lansdown House, Woodford Green, the wife of Arthur Robin, M.D., of a son.

#### Marriages.

Willoughby Lyle, M.D., F.R.C.S., of Hertford Street, Mayfair, and Eversley, Bromley, Kent, to Annie Seston, widow of the late David Thomson Playfair, M.D., F.L.S., of Bromley, and daughter of Edwin William Winton, of Speldhurst, Kent. STEVERS—CAMERON.—On May 8th, at Edmonton, Alberta, Canada, Reginald Charles Jeremie Stevens, M.B., of Olds, Alberta, elder surviving son of Sir John Stevens, of Bath, to Kathleen Edith, youngest daughter of the late Rev. Francis Marten Cameron, M.A., Rector of Bonnington, Kent, and of Mrs. Cameron, of Oxford.

#### Beaths.

LAWTON.—On May 23rd, at 16 Trinity Road, Bootle, the residence of his brother-in-law, Dr. R. R. Stitt, William Lawton, M.B., C.M., etc., youngest son of the late Rev. M.A. Lawton, B.A., Vicar of Kilnwick Percy, Yorkshire.

REYNOLDS.—On May 26th, at 172 Stapleton Hall Road, Stroud Green, N., Frederick Reynolds, L.R.C.P.Edin., L.M., M.R.C.S. Rng., aged 65.



# TABLOID' BRANT Pastilles





POSSESS DEFINITE AND ASSURED PHARMACOLOGICAL ACTION, PURITY AND ACCURACY OF DOSAGE



◆Tabloid' Brand Pastilles

- " Ammonium Chloride and Liquorice
- " Benzoic Acid Compound
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- ,, Codeine, gr. 1/8
- "Glycerin
- " Glycerin and Black Currant
- " Glycerin, Tannin and Black Currant
- ,, Glycerin, Tannin, Capsicum and Black Currant

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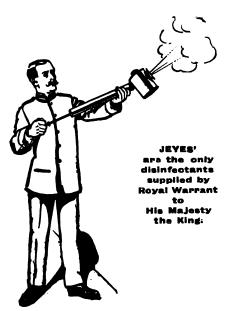
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TO H.M. THE KING.

# Routine Disinfection.

# A Suggestion to School Medical Officers.



The dust from the floors of elementary schools has been declared by the Lancet to come second only to that collected from the floors of public-houses, in the number and malignity of the disease germs it contains. The only practical, effective defence against this constant menace to the health of whole communities lies in the routine employment of a germicide of recognised standard strength. This is provided in

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which, by the simple device of appointing sanitary monitors in each class-room, can be applied to the floors of a whole school in a few minutes. The cost of systematic disinfection is so trifling as to be reckoned in farthings. Its employment has the endorsement of the Local Government Board, the Scotch Education Department, the President of the British Medical Association, etc., and it has already

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With a view to the prevention of infectious disease the Bucks Education Committee had the floors of twenty-five schools sprinkled nightly during the past twelve months with a solution of Jeyes' Special Fluid, the attendance in these schools being compared with that of the remaining schools in which the process was omitted. The official report shows an improved attendance in the disinfected schools sufficient to earn additional grants amounting to over £50, while the entire cost of disinfection for the twelve months was less than £30.

"To cleanse a school-room properly it is necessary to destroy the germ-life as well as to remove the visible dirt." (Scotch Education Department Memorandom, November, 1907.)

To the new School Medical Officers an exceptional opportunity is presented. They are in a position to preach the gospel of health with authority, and it will reflect immensely to their credit if they can point, as a result, to the continuous banishment of serious epidemics from districts under their charge.

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, JUNE 9, 1909.

No. 23.

#### Notes and Comments.

The Church and "Healing."

THERE has been a good deal of talk the last few months about associating the Church of England with the medical profession in a sort of mutual bond for the treatment of the

sick, the main idea apparently being that when the doctor thinks a little more faith and a little less medicine is required, he should apply to the parson to second his endeavours. For our part, we should advise the Church to enter on no such task, and we are quite sure the medical profession will not. Each body has its own defined sphere, and each does best when it confines itself within its own The truth appears to be that a certain section of the Church is being drawn towards Christian Science, falsely so-called, and the promoters of the new movement are seeking to provide counter-attractions within the pale of orthodoxy. The fact is, that in a large heterogeneous body like the Church of England there are sure to be, among the rank and file of sensible folk, a proportion of ecstatic individuals who are agog for something new and sensational, and the reputed "cures" of Christian Science, and assertions as to the early practice of some of the Christian Churches, have induced them to provide a healing system of their own, in which credulity bulks largely and from which reason modestly retires.

A Modern
"Hospice."

As the outcome, apparently, of this movement a hospice, it is announced, has been opened near Regent's Park for the practice of spiritual healing under the auspices of the Church.

The modus operandi consists in adopting the old formula of prayer and laying-on of hands, together with that anointing with oil which the Peculiar People lay such stress on and which brings so many children's bodies to the coroners' courts. According to a published interview with Mr. Hickson, the president of the hospice, the principles of this institute differ in some essentials from those of Christian Science and faith-healing, but we do not gather in what the difference lies. At any rate. the body to whom the hospice belongs are known as the "Society of Emmanuel," and it is asserted that institution is the first of its kind established in connection with the Church of England. sort of place it is may be judged from the following account given by a lady member of the Society:—
"Only the other day a distinguished cleric of the Church of England visited the hospice and told us how some time ago he was afflicted with cancer. The doctors abandoned all hope of cure. Then friends induced the patient to call in Mr. Hickson, who arrived on the morning of a day on which the sufferer was to undergo an operation. Mr. Hickson prayed with him and anointed him, followed by the laying-on of hands. In the afternoon the surgeon arrived and made his examination. He was greatly surprised. 'This case puzzles me,' he was did. 'There is the mark of a new wound, but the cancer has gone.' The cleric in question is now perfectly well. . . ." We would be satisfied to leave such pernicious nonsense alone, if it stood by itself, but when it is foisted on to the public with the hall-mark of the Church, we ask the Bishop of London if he is content to allow such a blot to stain his diocese?

The Profession
and "Indiscretions."

An article, purporting to be written
"By a Physician," appeared in the
Manchester Evening Chronicle of
May 28th, in which the question is
gravely discussed as to whether a

medical man is justified in giving a false certificate to shield a patient from the consequences of his own wrong-doing. The case quoted is one, said to have happened in Germany, in which a telephone girl, laid aside as the result of "indiscretion," was certified by her medical attendant to be suffering from influenza. The lie was found out, and the doctor prosecuted for giving a false certificate, with the result that he was condemned to a short term of imprisonment. In this country there is no law that we know of which would render a medical man liable under the same circumstances unless the certificate was a statutory one, to which a specific penalty for falsification was attached, as, for instance, in the case of death certificates. The writer goes on to argue that it is an open moral question whether such deception is right, and to insinuate that doctors are in the habit of sparing their patients who are suffering from over-indulgence in alcohol by saying that they are "run down and require a few days' rest." He further brings in the question of professional secrecy, and announces that the question is one of much perplexity.

Secrecy and Lying. It is grievous to think that any respectable journal should publish an article in which it is even suggested that it is an open question whether doctors are justified in lying, and we

make bold to say that we do not believe the article was written by any more substantial member of the profession than the now-proverbial "Harley Street Specialist" of the yellow press. No question of professional secrecy arises at all when an employee asks his medical man for a certificate. The certificate is given to him and he can use it or not as he wishes. No medical man can be bound to state, for the gratification of his patient's employer, what the patient is suffering from. But any

medical man who tells a lie and says a patient has influenza when he knows he is suffering from anything else, deserves to be expelled from the profession for disgraceful conduct, and we have little doubt but that he would be if such a case were brought to the knowledge of the General Medical Council.

#### LEADING ARTICLES.

THE NEW MILK BILL.

THE Milk Bill recently presented to the House of Commons by Mr. John Burns is undoubtedly a measure possessing features of great value, but, so far as we have been able to judge, it is, nevertheless, open to considerable improvement. Should our surmise be correct, it is to be hoped that the opinion of public health experts will be authoritatively ascertained, and the Bill amended, before it passes into its final stages. The importance of the purity of the milk supply of the nation is so vital that it would be a thousand pities were a safeguarding measure of the kind introduced by the President of the Local Government Board to be weakened by avoidable defects. The point to which most medical men will at once turn, in view of the advances of recent years, is the steps taken to exclude tuberculous milk. In the present Bill great pains have been taken to empower medical officers of health to follow up infected milk to its origin and to exercise more or less personal control on the spot, and at the same time to set in motion the local authorities. However excellent this plan may be in theory, we cannot help feeling a little doubtful how it would The urban medical officer of work in practice. health is, for the most part, a busy man, loaded with many responsible duties. In order to control the milk supply of his district, he must be provided with an ample laboratory and with a special staff of inspectors. Supposing him to have found time to surmount the first great obstacle of identifying the source of origin of a certain infected milk, the further demands upon his time and energies are considerable. The dairy centre implicated may be at any distance, say, twenty, fifty, or a hundred miles away. He has to travel thither and find out, if possible, the particular farm from which the infected milk came, or he may have to inspect several suspected farms. His visit is made with a veterinary inspector, and he has to inspect the cows it may be fifty or a hundred or more—in order to detect the tuberculous animals. At this stage he can only direct that none of the milk from these cows shall be sold for human consumption, and that he may enforce with an interim order from himself, pending an order from his own Sanitary Authority prohibiting, under penalty, any such sale. The new departure involved in this proceeding opens up various possibilities that require careful consideration. Under its agency we find some medical officer of health acting independently in the district of another medical officer, and we feel bound to say that we view the prospect thus disclosed with some apprehension. Mr. Burns provides further machinery for control in an Order from the Board of Agriculture, whereby the possessor of any cow suffering from tuberculosis of the udder, indurated udder, or other chronic diseases of that

organ, or from the emaciation of tuberculosis, shall give notice to a sanitary inspector or a police constable. The local authority of the district shall examine the animal, and if found tuberculous may order it to be destroyed, provided its value does not exceed £30, in which case its destruction can be carried out only with the consent of the Board of Agriculture. There is a further clause in the Bill imposing a penalty on any person who knowingly exposes for sale for human consumption tuberculous milk, unless the latter has been sterilised. Without going exhaustively into the points of the measure at this stage, a few obviouscriticisms may, nevertheless, be made with advantage. First and foremost, we are at present inclined to think that Mr. Burns has-to use a homely phrase-got hold of the wrong end of the stick in more ways than one. Instead of attempting to control the tuberculous milk-always a complicated and difficult prblem-he should adopt the more logical step of controlling the tuberculous cows. If it be found necessary for the medical officer of health to go into other districts in his quest for the origin of the infected milk, let him hand the tuberculous cows and dairies over to the local sanitary authority, to be dealt with then and there. Co-operation between urban and rural authorities we believe to be absolutely necessary as regards milk control, but that is a very different thing from a confusion and multiplication of administrations. If the examination of milk for tuberculosis germs be necessary, should it be not performed at the farms or dairies of origin rather than thrown upon the shoulders of consumers? Then there is the fatal flaw of leaving the inspection of farms to local authorities composed of persons whose interests are not furthered, to put it mildly, by a stringent administration of their duties. A system of central inspection and control, with the cost of extermination of tuberculous cattle thrown upon the imperial and not upon local taxpayers, is, in our opinion, essential to the framing of a solid and enduring Act. As regards the sale of tuberculous milk, it is obvious that the average dairyman can know nothing at all about the matter, and will evadepenalty on the condition "knowingly" appended tothe offence. It is to be hoped that the Association of Medical Officers of Health and other bodies of medical men will lose no time in discussing the various aspects of the Milk Bill before it passes into law. Mr. Burns will do well to get some authoritative medical advice and opinion outside that of the Local Government Board before the last. word is said in the House of Commons on his. present proposals, which we are happy to think, in spite of various defects, constitute a vigorous and, in some ways, a most commendable attempt in the right direction.

#### CURRENT, TOPICS.

The Taxation of the Motor-Cars of Medical Men.

We are glad to learn that at last a definite protest has been instituted by medical men against the injustice of taxing not alone their motorcars, but the petrol which they use in them. As we report in another column, a special meeting of the Motor Union Committee of Medical Motorists was held the other day, and was largely attended. The meeting resolved to approach the Chancellor with a view to securing a rebate of three-halfpence per gallon on petrol used by medical men. This is a step in the right direction, but even more important than it would be a protest from the British Medical Association or the Irish Medical Association. We understand that the latter body, at its annual meeting to be held this week, will have the matter before them, and we trust that some steps will be taken to bring the views of the Association before the Chancellor. In any action it takes, the Irish Medical Association should remember that medical men in Ireland are now being called on to pay not alone a petrol tax, but another entirely new tax for the car itself, as, up to this there has been no such thing as a carriage tax in Ireland. The result is that the medical owner of a single ten-horse motorcar in Ireland, who drives, say, five thousand miles a year, will have to pay five guineas a year taxation, while his neighbour, who may have numerous horses and carriages, pays nothing. It is to the interest of the public that medical men should be brought to use motor-cars, and this is hardly a good way to encourage them to do so.

#### Strawberries and Strawberry Litter.

Now that the strawberry season is at hand, we once again draw attention to a serious danger to health connected with the growing of the fruit for market. As the berries reach maturity their stalks bend beneath the weight until they reach the ground. In order to protect the fruit from the soil the growers are in the habit of putting down litter. The right and proper thing to use for the purpose is straw, but we regret to say that a pernicious habit has of late sprung up amongst market gardeners of using manure in any degree of rotten-This method is obviously dangerous to health, as it contaminates the strawberries with multifarious microbes, some of which are likely to be of a kind deleterious to the consumer. It is a fact well known to growers that strawberries that have been thus exposed are extremely apt to become decayed and mouldy. The method is undoubtedly economical, inasmuch as it saves the laying down of manure for the next crop. It is of so undesirable a nature, in our opinion, that the local rural authorities should be empowered to put a stop to it in the interests of the public health. It is simply a commonplace to observe that the origin of many summer maladies is obscure, and that not a few of them may probably be ascribed to contaminated fruit. It is surely not asking too much that the public should be protected against the dangers inseparable from the filthy practice of bringing ripe strawberries into direct contact with rotten manure.

#### Condition of Irish Factories,

It seems as if the North of Ireland were gaining a very scandalous notoriety for its neglect of all matters pertaining to the public health. The sanitary administration of Belfast and the condition of the primary schools in Belfast and the County Down have both been before the public of late years in a way not creditable to the people of the North of Ireland, who are usually regarded as

hard-headed business folk. The report of the Chief Inspector of Factories, published a few days ago, shows that the condition of many of the factories is as bad as that of the primary schools. Martindale, in her report, mentions that in two large towns factories were found in which the sanitary accommodation for women was most unsuitable, especially with regard to the want of privacy. In both cases notices were met with the assertion that the accommodation complied with the requirements of the standard laid down by the local authority, and in one case the factory had been visited by members of the Public Health Committee, who had expressed themselves to the occupier as being quite satisfied with the arrangements in question. Other cases are quoted in which conditions dangerous to health were due quite as much to the neglect of the sanitary authorities as to that of the proprietors. In many cases there was no heating of the work-rooms, and Miss Martindale found rooms with a temperature in March of 45°, where the air contained 3.28 parts of CO<sub>2</sub> per 1,000. When prosecutions were instituted, there was the greatest difficulty in gaining a conviction, or nominal fines were inflicted. Instances are also quoted of grave breaches of the Truck Act, and of improper conditions under which young children are employed. The whole subject is one deserving the serious consideration of the public, for, as Miss Martindale remarks, until opinion is roused the children of the Irish industrial classes will remain weakly and undersized, the high death-rate will continue, and the children will grow up as illiterate as their innate brightness and cleverness will allow.

#### The Future of Medical Education in Ireland

THE "Statutes of the National University of Ireland, and of its Constituent Colleges," as published last week, are of interest to the medical profession, in that they lay down the lines on which medical education in the new University is to proceed. We abstract the principal points in another column, but here we have to express our general satisfaction with the scheme drawn up by the Dublin Commissioners. In addition to the traditional medical and surgical degrees, the University is to grant degrees of B.Sc. and D.Sc. in the subject of Public Health. The constitution of the faculty of medicine in the Dublin College seems to be satisfactory. There are to be eleven professorships, and six lectureships, the minimum salary for a lectureship being £50, and the maximum for a professorship £800. Cork, too, is to have an adequate medical school, with ten professorships and five lectureships. The medical school in Galway has always been a difficulty, on account of the inadequate funds at the disposal of the College, and the lack of sufficient hospital material. No improvement is made under the new scheme, and we can hardly expect the school to hold its own against its better-equipped rivals. One teacher is still expected to deal with the entire subjects of anatomy and physiology, and no provision is made for the teaching of pathology! The College hardly seems wise thus to starve its medical school and to spend considerable sums in the teaching of dead languages. On the whole, however, medical education in Ireland

ought to be much improved under the new conditions.

The Proper Diet of Mankind.

DR. F. GOWLAND HOPKINS, speaking at the Royal Institution last week, is reported to have asked the question: "What would be the most efficient food of man?" The answer to that question he gave us by saying that the most sensible person is the cannibal, as he gets precisely the quality and proportion of the foodstuffs needed by the human body by taking them directly from that organism. In consuming his own kind he eats exactly the right stuff. As an instance, Dr. Hopkins quoted a Heidelberg experiment in which a dog was fed with dog-flesh, and was thus enabled to do with a much smaller quantity of protein than when fed with protein derived from any other source. The nearer species are allied, he argued, the less difference is there between the chemical constituents of the tissues of individuals, and therefore the less the work thrown on the processes of digestion and conversion, and therefore ape must be more nourishing to man than is beef or mutton. We cannot allow this cannibalistic theory to go forth as the dernier cri of science on the question of diet. The chemistry of food is a very vague state, and theories of dietaries are as numerous as they are conflicting. One thing, however, is certain, and that is that animals are divided into herbivora, carnivora, and omnivora. We can, therefore, no more agree that it follows that human flesh is the best diet for man than that horse-flesh is the best food for a horse. "Dog don't eat dog" is a good old proverb, and it will take several generations of physiologists to persuade us that the proper diet of mankind is man.

Egypt and Malaria.

THE remarkably outspoken utterances of Sir Ronald Ross at the Royal Institution recently attracted a good deal of public notice. It is interesting to compare with what was then said a question asked of Sir Edward Grey by Mr. Ramsay Macdonald in the House of Commons shortly before the Whitsuntide recess. The Foreign Secretary was asked if Mr. H. C. Ross had to leave the Egyptian Sanitary Service owing to his zeal for stamping out malaria; and if that was not the reason, why he had to leave. The answer was that Mr. Ross was never in the Egyptian Department of Public Health as a permanent officer, and he resigned his temporary post when he heard that the Director-General was not prepared to give him a permanent appointment in Cairo. It is, of course, a well understood farce in public life that the head of a department, in answering a question, gives, not his own view of the circumstances-for in ninety-nine cases of a hundred he has never heard of them before-but the reply prepared for him by the permanent officials. A flood of light bearing on the real circumstances is shed by a letter from Mr. H. C. Ross to the Times, of June 2nd. Mr. Ross points out that he was a surgeon in the Royal Navy, with, at least, the ordinary hopes of preferment and pension in the Service, but that, through the introduction of his brother, Mr. G. H. Ross, Medical Officer of Health

for Port Said and the Suez Canal, he was brought into contact with Sir Horace Pinching, Director of the Egyptian Public Health Department. seems that Sir Horace offered Mr. Ross a temporary post in the Service, with the reversion of the next vacancy if he gave satisfaction, and on the strength of these representations Mr. Ross resigned his appointment in the Navy and went into the temporary appointment offered. The work specially assigned to him was the initiation and carrying-out of an anti-malarial campaign, which he undertook con amore, and with some success. Soon after, Sir Horace Pinching resigned, and recommended to his successor that the vacancy thus caused should be filled by Mr. Ross's appointment. The new Director-General seems to have been a man of the old type who regarded the destruction of mosquitoes as a frivolous amusement and not as hygiene, and he appointed an Army medical officer to the vacant position. Mr. Ross consequently had nothing to do but to resign. We are giving the ex parte statement and nothing else, but we can only say that if the facts are as stated, the Egyptian Department of Public Health would seem to be conducted on principles at variance-let us say-with common decency. We trust that Sir Edward Grey will cause a special inquiry to be made into the circumstances for the honour of the country.

#### Holidays and Health.

During the past ten days it has occurred to many medical men to ask themselves whether the benefits to the community arising from occasional general holidays at all counter-balance the injuries. It is a general maxim that an occasional change does one good, and that holidays are a necessity. It is true that in the stress of modern city life, few people can continue to work year in and year out without a break, and maintain constant good health. For most of us holidays are, if not a necessity, at any rate something we cannot well do without. This is, however, quite a different contention than to hold that a day seized from business and devoted to some equally arduous pursuit of a less accustomed nature is fraught with good results to health and happiness. As a matter of fact, the strenuous bank holiday is often as injurious to the golfer or the man who, starting from his office-stool, takes a twenty-mile walk, as to the artisan's child who is made sick in honour of the holiday. It is said that as a people we take our pleasures sadly. It would be equally true to say that we take them foolishly. We make too much of a business of them; we are not content to idle, and for a brief holiday idling is probably best.

#### Irish Schools.

On many occasions during the past few years attention has been drawn to the scandalous condition of the Irish primary schools in matters concerning ventilation, sanitation, and heating. The subject was again brought before the public a week or two ago by a deputation of the Women's National Health Association which waited on Mr. Birrell. In his reply to the representations made to him, the Chief Secretary admitted the indefensibility of the present system, but was, at the same time, careful not to commit the Government to any

promise of help. It would appear that at present there is no public fund, either local or general, available for the upkeep or improvement of school buildings. In many cases, according to Mr. Birrell, the very fuel for heating the school is supplied out of the miserable salary of the teacher-a salary less than that of an artisan. The position taken by the State is incomprehensible. On the one hand it proclaims compulsory education. On the other, it leaves school buildings in such a condition that attendance in them is injurious to the health of children. We hold that the child's health is of infinitely more importance than his school education, and until the State insists on sanitary school buildings, it is doing a grave injury to the public health by demanding school attendance.

#### PERSONAL.

THE fourteenth annual meeting of the Guy's Hospital Ladies' Association has been held under the presidency of Princess Christian of Schleswig-Holstein.

A MEETING of the Socialist Medical League was at the Holborn Restaurant, London, on June 3rd, when Dr. J. Robb opened a discussion on "The Nationalisation of the Medical Profession." Twentynine persons were present.

THE Annual Welsh Medical Dinner will be held at the Criterion Restaurant, London, on June 15th, when the chair will be taken by Dr. D. C. Lloyd Owen, of Birmingham. The date has been selected for the Birmingham. The date has been selected for the convenience of those who will be visiting London for the National Eisteddfod.

DR. EDWARD LIVEING has resigned the registrarship of the Royal College of Physicians of London, which he has held for twenty years. The Council of the College has placed on record its appreciation of the devotion and energy with which Dr. Liveing discharged the duties of his office during so many years.

THE members of the Council of the Royal College of Surgeons of England who retire this year by rotation are Mr. A. W. Mayo Robson, Sir W. V. atson Cheyne and Mr. R. Clement Lucas. We understand that Mr. Harrison Cripps and Mr. W. W. H. Jessop, of St. Bartholomew's Hospital, intend to offer themselves as candidates at the next annual election.

A NUMBER of retired Indian medical officers, who could not attend the annual dinner in London, dined in Edinburgh on May 28th, at the Caledonian United Service Club, Sir Alexander Christison, Bart., occupying the chair. Among those present were Surgeons. General Bidie, C.I.E.; Turnbull, K.H.S.; Sinclair, C.S.I.; and Hay. The guests included Dr. Allan Jamieson, P.R.C.P.; Mr. Cotterill, P.R.C.S.; Colonel Corker, R.A.M.C., P.M.O.; Sir Halliday Croom, and Dr. MacBride.

MR. GRAFTON ELLIOT SMITH, Professor of Anatomy at the Government School of Medicine, Cairo, has been appointed by Manchester University to the Chair of Anatomy, in succession to Professor Young, resigned. Professor Smith was educated at the University of Sydney, New South Wales, and was appointed successively Demonstrator in Anatomy and King Travelling Fellow in the University of Sydney. He continued his work at Cambridge, and obtained a Fellowship of St. John's College, and was University Demonstrator of Anatomy.

Dr. D. EDGAR FLINN, Medical Inspector under the Local Government Board of Ireland, and Dr. W. J. Howarth have been elected Fellows of the Royal Sanitary Institute.

THE annual meeting of the Birmingham Medical Benevolent Society was held on May 25th. Dr. Malet, the retiring President, was in the chair, and he was supported, among others, by Sir James Sawyer and Sir Thomas Chavasse. The eighty-seventh annual report states that the invested funds of the society amount to £15,940, with a balance of £120 98. 7d. at the bank. Sir Thomas Chavasse was elected l'resident and Dr. Simon President-elect.

In the annual grant voted by Parliament in aid of scientific investigations into the causes and processes of disease, the President of the Local Government Board has authorised researches by Dr. Theodore Thomson, Medical Inspector of the Board, in conjunction with Dr. Hedingham, of the Lister Institute; Dr. Theodore Thomson and Dr. C. J. Thomas; Dr. Dr. Theodore Thomson and Dr. C. J. Thomas; Dr. Monckton Copeman, Medical Inspector of the Board, and Professor Nuttall, of St. Bartholomew's; Dr. Andrewes; Dr. Savage; Dr. Schölberg and Mr. Wallis, of University College, Cardiff; Dr. Darwall Smith, Physician to the British Lying-in Hospital; Dr. Inman, Pathologist to the Brompton Hospital for Consumption; Dr. J. Hiller, Pathologist to the General Hospital, Birmingham.

SIR RUBERT BOYCE, Dean of the School of Tropical Medicine, who has been visiting the West Indies under the auspices of the Colonial Office, for the purpose of reporting on the present methods of dealing with sickness in these Colonies, returned to Southampton on Sunday last (May 30th) in the Orinoco. The visit was arranged on the suggestion of Mr. Owen Philipps, M.P., Chairman of the Royal Mail Steam Packet

THE National Association for the Prevention of Con-THE National Association for the Prevention of Consumption and other Forms of Tuberculosis is now holding a free Tuberculosis Exhibition for the education of the public, and more εspecially its poorer sections, at the Art Gallery, Whitechapel, and it will remain open until June 19th. On June 2nd the opening address was given by the Right Hon. John Burns M P Burns, M.P.

At the conference to-day "The Treatment of Consumption" will be dealt with by Dr. Arthur Latham, Physician to St. George's Hospital; Dr. Paterson, Superintendent of the Frimley Sanatorium; Dr. Jane Walker, Superintendent of the East Anglian Sanatorium, Nayland; and Dr. H. W. McConnel.

To-MORROW will be devoted to "The Prevention of Consumption," and the papers will be read by Dr. Duncan Forbes, Medical Officer of Health, Brighton; Dr. E. W. Hope, Medical Officer of Health, Liverpool; and Dr. J. Edwin Squire, C.B., Senior Physician to Mount Vernon Hospital for Consumption. Evening lectures are being given at the sumption. Evening lectures are being given at the exhibition, and the lecturers include:—Dr. C. Theodore Williams, Dr. Frederick Rose, Dr. Newsholme, Medical Officer to the Local Government Board, Professor G. Sims Woodhead, Dr. Hector Mackenzie, and Dr. Nathan Raw.

THE Twelfth International Congress on Alcoholisms will be held in London from July 18th to 24th. H.R.H. the Duke of Connaught is honorary president, and! Lord Weardale acting president. On Sunday, July: 18th, the Official Sermon will be preached by the Bishop of Croydon at the afternoon service in St.: Paul's Cathedral.

On July 19th the Inaugural Address will be given-On July 19th the Inaugural Address will be given-by the Acting President, and in the afternoon the-exhibition will be opened by the Dean of Hereford, Chairman of the Conveners, while the evening will be devoted to the official reception. Papers will be read at the Congress by Professor Taav. Laitinen, M.D., Dr. A. Holitscher, Dr. Legrain, and Dr. Stein. British contributes are to be read by Professor Sims Woodhead, M.D., Dr. W. H. R. Rivers, F.R.S., Professor Clouston, M.D., Dr. F. W. Mott, F.R.S., and Dr. R. W. Branthwaite, H.M. Inspector under the Inebriate Acts.

#### CLINICAL LECTURE

#### THE EXTRACTION AND CUTTING OF THE ROOTS OF THE TRIGEMINAL NERVE, AS AN OPERATION SUBSTITUTING THE EXTIRPATION OF THE GASSERIAN GANGLION.

By PROF. JULIUS DOLLINGER, M.D.,

Professor of Surgery at the University of Budapest.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

Gentlemen,—It is most flattering to me to be able to lecture again here (a) on the same subject I selected for my address last year, and which has given rise to such a valuable discussion on the part of members of the Association. Then I dealt with the question of the extirpation of the Gasserian ganglion; now I will endeavour to speak on the merits of the extraction of the nerve roots.

In my former lecture I pointed out that the extirpation of the Gasserian ganglion is dominated by excessive hæmorrhage, and that the obviating of this causes great anxiety. Further, that in some cases even the mere approach to the ganglion causes serious bleeding, which is further increased by the opening of the cavernous sinus when extracting the ganglion. The opening of the sinus occurs almost in every instance, in consequence of the anatomical relations existing between the first branch of the trigeminal nerve, the inner side of the ganglion, and the lateral wall of the cavernous sinus. In order to evade the opening of the sinus, and the hæmorrhage resulting from this manipulation, I have separated—as mentioned in my previous lecture—all the surfaces of the ganglion (excepting of course the inner one) from their surroundings; then I have pulled out from under the tent the root of the trigeminal nerve, and cut the second and third nerve-branches before their exit out of the skull, leaving intact that part of the ganglion which is ingrown into the lateral side of the cavernous sinus, while I removed the lateral parts of the ganglion, together with the stumps of the second and third branches which originate therefrom. In one case I was successful, while in another the sinus opened when the ganglion was excised, thus causing most profuse hæmorrhage. These two cases have taught me to pull away in front the nerve roots independently from the ganglion, as I anticipated in my last year's lecture.

I will now quote a few instances where I have performed this operation successfully. My first patient was an army officer, æt. 35, who suffered from severe trigeminal neuralgia for six years and a half. Four years ago a few nerve branches were resected, but this operation gave only temporary relief. I subsequently operated on April 28th, 1908, having previously ligatured the external carotid artery, the consequence of which was that the excision of the temporal flap and the opening of the skull caused less hæmorrhage than is generally the case. As the middle meningeal artery bled considerably I ligatured this also. Then I separated the tent from the edge of the petrous bone at the site where the roots of the trigeminal nerve enter the scala media, caught the roots in clamps, and extracted them from under the tent, and cut them in a central direction from the ganglion; this latter I left untouched. length of the extracted roots was 31 cm., and their width 6-8 millimetres. I then sutured the wound without any drainage. I should state that imme-

diately after the operation the pupil of the eye on the side operated upon had not contracted, nor did the tension of this eyeball decrease. In several other cases the occurrence of these symptoms has directly followed the operation. (According to Morat, the carotid plexus of the great sympathetic nerve sends a branch to the Gasserian ganglion, which branch contains the dilating fibres of the pupil. Testut, "Traité d'Anatomie Humaine," I., II., p. 778.) With the Gasserian ganglion a piece of this sympathetic branch, too, is removed, in consequence of which the pupil contracts, while if the Gasserian ganglion, and with it the Morat sympathetic branch, remains uninjured, the contraction of the pupil does not set in. Besides the safety of the ganglion, the operation has the undoubted advantage of insuring that the nutrition of the eye does not suffer.

I examined this patient eighteen days after the operation, and found that his skin, cornea, the mucous membrane of the nose and stomach were quite anæsthetic on the affected side, and not hyperæsthetic, as in the cases of Taboulay. On the affected side the sense of taste was wanting on the point and rim of the tongue; the masticating muscles were paralysed, with the exception of the temporal muscle. The patient could masticate on the sound side. The secretion of the mucous membranes and of the lachrymal gland did not undergo any changes. The neuralgic pains have since entirely abated, and on October 5th, that is, after five months, all these good symptoms were unchanged, the patient has resumed his military service and is quite healthy. Thus this case proves that for the cure of a trigeminal neuralgia it is not absolutely necessary to remove the Gasserian ganglion, but it suffices to extract the trigeminal root, as advised by Van Gechuchten. The operation ran so smoothly and was so devoid of difficulties, that it would tempt one to declare it to be without danger, and to believe that we have conquered the many difficulties which surrounded this operation.

Referring to this operation, Dr. Morestin has remarked that the laceration of the trigeminal roots, and by that the separation of the Gasserian ganglion from the central nervous system, is equivalent to the extirpation of the ganglion, and that as it is easier and less dangerous, it is more

advantageous than the latter.

During the last week, however, I had the opportunity of performing the operation twice, and these new experiences have led me to believe that Morestin considers the operation from a too optimistic point of view. In my first case the dura mater was easily lacerated, and as I separated it from the skull it became torn, so that the cerebral gyri became visible, and the careful lifting of these and their exposure aggravated the separation of the trigeminal roots considerably. When finally succeeded in accomplishing this, and could grasp the root, it gave way, and its central end was withdrawn under the tentorium cerebelli, so I could catch only a few insignificant nerve rootlets with the

<sup>(</sup>a) This lecture was delivered before the members of the Surgical Congress in Paris.

aid of my forceps; but at the same time severe arterial bleeding commenced in the deep part of the wound, so that, assuming that somehow I had injured the internal carotid, I instantly tamponaded the base of the skull and ligatured the common carotid artery. I had no opportunity of ascertaining whether I had torn the trigeminal root entirely across or not. After five days I removed the tampons, examined the area of the operation, and found that I had entirely torn away the root; moreover, the same symptoms were manifested as in the previously-described case, where the extraction of the trigeminal root has been done in so ideally successful a manner. The ligature of the common carotid artery did not cause any symptoms. The patient has since entirely recovered.

On the next day I performed the same operation on a woman, æt. 35. Upon lifting of the dura mater, such a profuse, uncheckable hæmorrhage occurred from the Santorinian emissaries, that I was unable to survey the field of the operation, and therefore I could not be sure whether I had torn across the root entirely or not, because the bleeding forced me to tamponade the wound and to close it. As after the operation neither the affected side of the face nor the masticating muscles became anæsthetic, three days after the operation I disunited the wound again, and thoroughly examined the Meckel cave. However, I could not find any trace of the root. The face has since remained unanæsthetic, and the masticating muscles have been in working order.

Thus the first of the three operated cases has given us the lesson that in a favourable case we may easily succeed in extracting the trigeminal root entirely; but the second and third cases have shown that this cannot be taken as a rule, for the laceration of the root in these has revealed certain difficulties which it must be our endeavour to guard

against.

The cases hitherto operated upon, however, have proved that we may cure a severe neuralgia as well with the laceration or extraction of the trigeminal root as with the extirpation of the Gasserian ganglion. In those cases wherein I have extirpated the Gasserian ganglion, I have usually extracted also the nerve root (in twenty-two cases), together with the ganglion. I did not see any harmful consequence from this manipulation. The other less severe consequences may be expected to arise from the extraction of the root itself.

Moreover, it may be that it will be sufficient simply to cut the nerve root between the ganglion and the tent, as advised by Professor Tendrassik. The fibres of the nerve root do not possess sheaths, and therefore it is not probable that they will grow together after dissection. From a physiological point of view, it would be a great advantage, and from the technical point an achievement, if we could cut entirely the strong sensitive root, and so preserve the thin root containing the motor fibres of the masticating muscles.

A physiological advantage of the extraction or dissection of the nerve root over the extirpation of the ganglion is that we leave the sympathetic nerve passing from the carotid plexus to the eyeball, with the mediation of the Gasserian ganglion, untouched; this is done by leaving in the Gasserian ganglion, in consequence of which the pupil does not get contracted, and its innervation remains undisturbed. It is possible that this nerve, as well as the left Gasserian ganglion, it of a beneficial effect upon the nutrition of the eyeball, and that with the relinquishing of these formations the eye

will be less exposed to those trophic changes which

follow extirpation in some of those cases where the patients do not sufficiently take care of their eyes and neglect the surgeon's instructions. On these points experience in the near future will enlighten us. As for the technique, the operation needs as much skill, anatomical expertness and experience as the extirpation of the Gasserian ganglion; it has, however, this advantage over it, that with it we can avoid that bleeding which originates from the cavernous sinus and which follows the removal of the ganglion.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Edmund Cautley, M.D. Cantal F.R.C.P.Lond., Physician to the Belgrave Hospital for Children, and to the Metropolitan Hospital. Subject: "The Treatment of Broncho-Pneumonia."

#### ORIGINAL PAPERS.

# THE ESSENTIALS OF PHYSIOLOGICAL HISTORY.

By DAVID FRASER HARRIS, M.D., B.Sc.Lond., Lecturer on Physiology in the University of Birmingham.

ABSTRACT OF LECTURE III.

The School of Hippocrates, although it knew that wounds of the brain caused paralysis on the opposite side of the body, had no physiology of the nervous system. Hippocrates wrote on epilepsy and hysteria, yet he used "neura" as meaning "sinews." Aristotle, believing the brain bloodless, imagined it secreted "pituita," which entered the nose through the ethmoid bone. Erasistratus of Alexandria, the first to affirm nerves arose from the brain and not from the heart, was also the first to distinguish sensory from motor nerves.

Herophilus, eponymous for the "Torcular," invented the term "calamus scriptorius." Aristotle had placed the soul in the heart, Hero-

philus believed it to be in the brain.

Galen knew almost more of the anatomy of the nervous system than of the vascular. He had notions of separate paths of conduction within the spinal cord, he displayed the brain in five steps of dissection, but he classified the cranial nerves on the basis of seven pairs.

Achillini of Bologna (1463-1512) described the appearance of what we now call the "Fornix" and "Hippocampal region," and saw the lateral

ventricles.

Berengarius (1470-1530) corrected previous errors, particularly that the optic nerves were the first pair.

Vidus Vidius (died 1569) gave his name to the

'Vidian '' nerve.

Vesalius (1540) knew that nerves were only conductors of impulses, and that section of the spinal cord deprived parts of sensation and movement. He knew a good deal about the comparative anatomy of the brain from fishes upward. In particular he could not accept the dogma that the "anterior" ventricle is for sensation, the middle for imagination, the posterior for memory.

Eustachius (died 1574), C. Varolius (1543–1575) and J. C. Arantius (1530–1589) all advanced our knowledge of the cerebral nervous system, Varolius leaving his name in the Pons and Arantius coining "Hippocampus."

The views of Paracelsus on the "archaei," and

of van Helmont on "Blas" were noticed, the latter placing the soul in the pylorus of the stomach.

The notions of Thomas Willis (1621-1675) were reviewed; he thought that sensory images were imprinted on the corpus callosum, the corpus striatum acting as a lens below. Willis was the first person to have any idea of reflex action, he speaks of "animal spirits" rebounding from within outwards in a reflected wave.

René Descartes (1596-1650) elaborated a complete but mechanical theory of neural activities. The "rational soul" he banished to the Pineal gland whence it directed bodily activities after the manner of a "fountaineer controlling the activities of fountains and other mechanical devices, working apparently automatically in royal gardens, grottoes, &c.

Nicholas Stensen (Steno) (1638-1686) had more than glimmerings of cerebral localisation of function. He despaired of the unravelling of the nervous system until a far better method than any he knew of preparing it should be discovered. We had to wait 200 years for this "better way."
Raymond Vieussens' "Neurologia Univer-

salis" (1685) added much to knowledge of the structure of the nervous system. Vieussens was one of the ornaments of the medical school at Montpellier (1641-1716).
Stahl introduced the "anima sensitiva" which

helped physiology no more than his "phlogiston"

had helped physics.

At the beginning of the 17th century, Dr. Harris said, research was branching out in so many different directions that we had the history of discoveries of regions of the nervous system to consider, viz.:—Spinal cord, medulla oblongata, pons varolii, cerebrum, cerebellum, peripheral nerves, including the "sympathetic system" and nerve cells themselves.

Time allowed only to follow the history of knowledge of the spinal cord and reflex action and of cerebral localisation. Boyles, Hales, Descartes all contributed to knowledge of the spinal cord.

Robert Whytt, of Edinburgh (1716-1766) discovered the light iris reflex, and did much for the physiology of reflex action without using the term. Spallanzani, in Italy (1768), and Herbert Mayo, in England (1823), advanced our knowledge of the cord. Sir Charles Bell (1778-1842), a native of Edinburgh, in 1811, made the exceedingly important discovery that the posterior roots conveyed ingoing fibres, the anterior roots outgoing. This "Law" was confirmed and extended by Magendie in 1822. In 1832, Marshall Hall coined the term "reflex nerve arc," and investigated reflex action from the clinical standpoint. He studied the reflex maintenance of tonus. With the subsequent history of this subject the names of Grainger, Schiff, Goltz and Ewald are associated.

Although Cerebral localisation had been vaguely believed in for a long time, until 1870 it was thought that the cortex cerebri was inexcitable to artificial stimuli. Haller (1708-1777) in particular tried every possible stimulus without eliciting any visible effects. The phrenologists held the doctrine of cerebral localisation in so grotesque a manner that the idea fell into discredit.

J. J. Gall (1758-1828) certainly thought the centre for speech was where Broca in 1861 proved it to be, the left inferior frontal convolution in

right-handed people.

Fritsch and Hitzig, surgeons in the Franco-Prussian war, found the cortex cerebri of a wounded man excitable to electric stimulation. Ferrier, before 1876, had confirmed and extended their work.

Later researches here and abroad have abundantly corroborated the doctrine that sensations and movements are represented topographically, or are related to different regions of the brain.

The important contributions of Flechsig, the elder Waller (1850), Helmholtz (1850), Furkinje, Waldeyer, Golgi, Ramon-y-Cajal, and Nissl were very rapidly seviewed.

#### EYE-STRAIN (ASTHENOPIA). (a) By GEORGE A. BERRY, M.B., F.R.C.S., F.R.S.E.,

Consulting Ophthalmic Surgeon to the Edinburgh Royal Infirmary ; Lecturer on Ophthalmology to the Edinburgh University.

In opening a special discussion on this subject, the author observed that he preferred the oldfashioned word, asthenopia, to the newer "eyestrain"; when qualified by such adjectives as nervous, accommodation, muscular, and the like, it conveyed a definite meaning. As a first class of cases in which eye-strain might occur he instanced those which were characterised by a sensation of conjunctival or corneal irritation, and watering of the eyes. This might be produced by reading in an unsuitable light, particularly if the illuminant contained too many of the more actinic rays. In reading out of doors, for instance, the light reflected from the white paper contained an enormous number of these rays. The same was the case with some of the modern incandescent illuminants. Reading in bed was frequently stated to be a cause of weakness of the eyes; it was probably not the position assumed, but the fact that often only the imperfect light of a single candle was used, that gave rise to the sense of discomfort. In cases in which it was desired to protect the eyes from the effects of excess of atinic rays he found London smoked glass perfectly satisfactory. It was formerly the practice to keep patients suffering from eye symptoms caused in this way in the dark for a considerable period. This was an unnecessary severe line of treatment, and also made the eyes unduly sensitive to light.

Turning next to eye-strain from refraction error, he laid particular stress on lid pressure as a cause of headache. Where a patient had astigmatism of a moderate degree, he was able, by compressing the globe with the eyelid, as in the act of frowning, to improve the vision by correcting the error. The effect of pressure with the finger on the eyeball could be made out with the ophthalmometer, and in some cases the effect of lid-pressure in altering the refraction of one axis of the eve could also be demonstrated in the same way. In patients who suffered from headaches due to astigmatism, a history of frowning was often obtainable. It had at one time been supposed that in these cases the refraction error was corrected by an irregular contraction of the ciliary muscle, but, as a matter of fact, this was an error.

In correcting astigmatism he had entirely given up using cycloplegics. Their effect on cases of astigmatism depended entirely on the variations in the size of the pupil they produced, and in their

(a) Abstract of paper opening a discussion at the Edinburgh Medico-Chirurgical Society, June 2nd, 1909. The discussion will be found on page 586.

allowing more of the marginal rays of light to enter the eye than when the pupil was contracted. In another class of case eye-strain was due to failure of the associated movements of convergence and accommodation, whereby, when the eye converged on a point in space, they were no longer accommodated for the same point. In America great attention had recently been devoted to muscular imbalance as a cause of eye-strain. Mr. Berry stated that in nearly every person carefully tested some degree of deviation of the axis of the eyes was present. While it was perfectly easy to keep the eyes parallel in moving them laterally or upward, if they were directed straight forward, without being fixed on any definite object, some degree of divergence or convergence was usually present. He therefore attaches no importance to this abnormality. Marked deviation of one eye upward or downward was, however, in a different category. It was not due to muscular action, but to an anatomical asymmetry of the orbit. It could be corrected by suitable prisms. number of cases asthenopia was due to purely nervous or hysterical causes. These cases were often cured by suggestion or any sudden and strong impression. He had sometimes been able to cure them by subcutaneous injection of distilled water in the frontal region.

In connection with the question of the symptoms of eye-strain, the author pointed out that it was, on the whole, the slighter cases of astigmatism in which by lid pressure, etc., it was possible for the patient to improve his vision, that headache occurred. If the refractive error was too great to be improved in this way, no eye-strain occurred. Mr. Berry advised that all cases of migraine should have the eyes examined, because in some the remedying of any refractive error cures the condition. considering the class of headache most often due to ccular defects, he thought that relief was most likely to be obtained from glasses when the headache definitely followed using the eyes. He thought that in some cases headaches were really due to gout; in old people this did not often escape notice, but in children it was more liable to do so.

#### HIGH FREQUENCY CYTOLYSIS FULGURATION OF CANCER.

BY J. A. RIVIERE, M.D.PARIS, Rédacteur-en-chef des Annales de Physicothérapie

In the paper I read before the Congress of Medical Electrology and Radio-therapy (Paris, July 27th—August 1st, 1900), I called the attention of medical men to a main and primordial fact—namely, that localised high frequency currents exercise an elective, destructive and specific action on cancer cells.

I added, in this first stage of my investigations, that the application of effluves and sparks was followed by rapid elimination of the neoplastic tissues, and that any loss of substance so caused was rapidly filled up. I asserted, moreover, that even if the knife was required for the removal of large tumours, it was not less indispensable to employ high frequency "scintillation" to the surgical wound in order to disinfect it, to drain it in a certain degree in a specific manner, and finally to prevent recurrence of malignant neoplasms.

Finally, I have maintained since 1900 that these therapeutic measures were the only ones which could be rationally brought forward in the treatment of inoperable tumours, and since that time I have spoken of the necrosis of plastic tissues exposed to the action of sparks-of the disappearance of induration, of ædema and of glandular enlargements, of the appearance of an abundant inodorous laudable serous discharge, which has taken the place of the original fœtid ichor-of the analgesic, cicatrising and vitalising action of this

electric modality on the process of repair, which in my subsequent works I have called "sclerogenous processus" ("Annals of Physical Therapy," January, 1904). I also noted the remarkable amelioration in the general condition, which kept time with the excellent local modifications.

From the preceding, is it not correct to conclude that I was the first to think of utilising high frequency currents for the treatment of malignant tumours? In my communication to the Congress of Medical Electrology and Radiology (Paris, July-August, 1900) I expressly called attention to the thick sparks obtained through the medium of Oudin's resonator, and I concluded by saying:—

"They begin by producing a thermo-electro-chemical action (a) which has the effect of eliminating the neoplastic tissues, and, if we admit the parasitic theory, of destroying the micro-organisms and their toxins; and, in the second place, they cause a tropho-neurotic curative action which restores the vital processus to its normal state."

Evidently it would not be a question of employing thermo-electro-chemical action to eliminate large thermo-electro-chemical action to eliminate large tumours for which surgical ablation would be indi-cated, but the surgical measures should be supplemented by preventive and curative treatment directed against the possibility of recurrence.

High frequency currents, and more especially monopolar effluves (b) emanating from Oudia's resonator seem to exercise this action by modifying the vitality of the fresh regions contaminated by the incisions of the surgeon (c) after having disinfected and drained them. This special mode of applying electricity seems at present to be one of the only therapeutic methods worthy of trial in cases of inoperable tumours.

In my 1900 treatise, speaking of the electro-thera-peutic cure of local tuberculous affections, I clearly pointed out the rapidity with which loss of substance was filled up; the strangely æsthetic character of cicatrisation, etc. I admitted the hypothesis of a defective nervism to explain the inordinate proliferation of the neoplastic cells and the feeble resistance they showed to the mono- or bipolar effluves and sparks.

In my communication to the Academy of Medicine Obscimber 8th, 1903), "Physico-therapy as applied to the Cure of Cancer," I showed a series of cases which had been benefited by the combined action of high frequency sparks and effluves combined with Röntgen rays; at the same time I spoke of the elective action of these two agents on the neoplastic cell and of the advantage of utilising them in concurrence and alternately during the course of treatment.

Dr. A. Darier, the well-known ophthalmologist, sent me a lady who presented growths which, under examination by the eminent histologist, Jean Darier, at the laboratory of the College of France, had been recognised as alveolar sarcomata of Billroth. patient was cured whilst under my care of multiple tumours of the neck, of the orbital cavities and of the mediastinum by the combination of high frequency sparks and effluves with the Röntgen rays. This was the first case of malignant tumour, the iagnosis of which had been verified by histological

(a) The thermic action must not be eliminated. I consider it even beneficial. It causes no inconvenience to the patients. I have seen cases which, under the sole influence of the analgesic action of high-frequency scintillation, have tolerated on the most tender spots the longest and most highly nourished brushes and sparks for about twenty minutes. The necrobiotic action of the spark and of the effluve, which I was the first to point out in a paper read to the Academy of Medicine in 1903, is most manifest in such a case.

(b) In subsequent works I have often made use of the word "effluvation," to indicate the high-frequency "conflagration" brought about generally by effluves and sparks. The barbarism, "etincelage," "sparking," I have avoided. When surgical measures have been complete, effluvation is sufficient; when the surgeon has leftneoplastic masses or infiltrated tissue, sparks are more efficacious. Here, to speak truly, we have not a question of operative "chniqua" as has since been stated, but a simple one of appreciation which the electro-therapeutic expert and the least experienced surgeon are able to understand. The effluve is the spark reduced to a spray; to obtain it, it is sufficient to remove the electrode to a greater distance; its striking action is more marked and penetrates more deeply because its voltage is higher. Short sparks on the contrary have a high amperage.

(c) The expression "solution of continuity caused by the operation" indicates that according to the pleasure of the surgeon, effluves and sparks can be utilised during all the steps of the operation.

examination, being cured by physical agents; it was certainly a case which carried conviction.

In the same communication to the Academy, I brought forward, amongst others, a case of epithelioma of the tongue, one of ulcerated carcinoma of the breast, two of uterine epitheliomata, in one of which the disease had recurred; in all these cases complete results were obtained by the same method.

Since then many patients, the subjects of malignant tumours, have been placed under my care and all have derived benefit from high frequency in the form of

effluves and sparks.

In the "Annals of Physico-therapy" (January, 1904), In the "Annals of Physico-therapy" (January, 1904), "Analytical Thoughts on Cancer and its Treatment by Physical Therapeutics," I gave a long explanation of the cytolytic action of high frequency sparks and effluves; "of their tropho-neurotic power, which is the cause of the subsequent retrogressive mortification, the effect of vaso-motor contraction and obliteration of the precessity of pushing the treatment. arterioles . . . of the necessity of pushing the treatment as far as elimination of the necrobiotic products reabsorbed by the organism." . . . In this work I added: "That ordinary surgery very often does not reach the limits of the infection, in spite of very free incisions, and that it is necessary to pursue the morbid cells into their last strongholds. The curative influence of high frequency sparks and effluves and of the X-rays," I went on to say, "shows itself to be far more precise and far more distinct, and therefore it precludes failure and recurrence, by reaching on the one hand, owing to their power of penetrating the deeper tissues, the generating roots of the tumour, which are really the abettors of the increase of the growth, and by neutralising, on the other hand, those formidable toxins which are gradually elaborated in the inmost and latent depths of the anatomical elements." ments." Subsequently I remarked: "The method in question seems to restrain the genesis of all newlyformed tissues which have been engendered by a vicious and disordered activity of the cellular anatomical elements.'

I returned to the consideration of the same questions a: "My Views on the Cancer Microbe"; "A Conin: "My Views on the Cancer Microbe"; "A Convincing Case of the Cure of Deep Sarcoma by Physical Therapy" (Annals of Physico-therapy, January, 1905); "High Frequency Effluves and Sparks for the Rational Cure of Malignant Tumours" (Gasette des Hôpitaux. November 14th, 1907); "High Frequency Effluves and Sparks in the Treatment of Malignant Tumours" (French Congress of Medicine, Paris, October 14th—16th, 1907); and, finally, in: "High Frequency Effluvation and the Cure of Neoplasms" (Second International Congress of Physico-therapy, Rome, October national Congress of Physico-therapy, Rome, October

13th-16th, 1907).

In all these papers I spoke of the difference that existed in the action of the mono- and bipolar sparks and effluves-of the appropriate electrodes for each case-electrodes of different metals for ionic action which we have not yet been able to differentiate; condensating electrodes, of varied shape and capacity, which allow the application to be made to the deepest parts of cavities. I showed the necessity of having recourse to high frequency and Röntgen ray applications at more or less close intervals during cicatri-sation in order to prevent recurrence, but not to the exclusion of the application of effluves and sparks to the wound made by the knife at the time of operation. I spoke also of the absolute necessity of attending to the diathetic arthritic condition of the patient, of looking after his food and his general hygiene; finally, I brought to light the great importance of assisting the elimination of the necrosed parts with reference to their return in bulk to the general circulation.

High frequency effluves, both large and small, exercise an evidently destructive action on the neoplastic cells which, under their influence, rapidly disaggregate; this is proved by an early increase in the size of the cancer wound; the healthy tissues, on the contrary, show a determined resistance to the effluves, and only become disorganised after localised and long continued applications of short warm and thick high frequency

sparks. These last should measure from 1 to 10 centimetres; the longest ones produce a deep, striking and penetrating action, which consequently is of great utility in visceral tumours. visceral tumours. This striking and penetrating action is deeper and more marked in bipolar sparks and effluves

The friability of the cancerous cell in the presence of high frequency "scintillation" is such that the neoplastic cell seems to vanish and disappear after a short time by a process of deliquescence, and this is the case, not only with regard to the spark, but even to the effluve.

Effluvation should be preferred when it is necessary to modify specially delicate parts, those which have been less deeply affected or only infiltrated. For this reason I give it the preference in certain cases for the modification of the wound caused by the surgeon's the modification of the wound caused by the surgeon's knife, when the operation itself had been considered radical.

High frequency "scintillation" is a powerful anæsthetic, as d'Arsonal has shown from the very first. The first shock, to speak the truth, takes the patient by surprise, and is painful only to a very small degree, but almost immediately he becomes accustomed to it and soon bears without any pain sparks of any dimension or thickness, even the thickest sprays, and remains perfectly quiet during the entire duration of the sitting.

Chloroform is absolutely useless for all superficial and accessible tumours; those situated in cavities necessitate special isolating and localising electrodes. Thus, Doumer's condensating electrode is very serviceable in certain cases, as it protects the surrounding parts, besides by modifying its construction it can be made to give scintillations of pretty various lengths.

Large tumours and visceral neoplasms necessitate the

knife, and at first general anæsthesia.

High frequency "scintillation" given in the form of sparks or effluves exercises considerable antiseptic action by reason that it generates a large quantity of ozone at the commencement of its action. The electric and thermic forces exercise also this beneficent When sparks have been employed, drainage of the wound becomes necessary in order to eliminate the necrosed cells.

Effluves employed on healthy cells, far from producing mortification, hasten, on the contrary, the process of cicatrisation, and, far from prejudicing union by first intention, they act in such a way as to materially assist the advent of this auspicious result. Union by first intention, however, should only be sought for in those cases in which the surgeon considers he has performed a complete and radical excision of the growth.

#### CONCLUSIONS.

(1) I was the first to draw attention to the elective specific action of high frequency sparks and effluves on malignant neoplasms at the Congress of Medical Electrology and Radiology (July 27th—August 1st,

(2) Since 1900 I have urged the necessity of completing surgical operations on large malignant tumours with high frequency "scintillation" applied to the surgical wound so as to disinfect and to drain the new regions contaminated by the knife, and by so doing to avoid recurrence. This method has since been called "Fulguration." Since then I have added that high frequency "scintillation" constitutes the only therapeutic method of dealing with inoperable growths.

(3) As I pointed out in my communication of 1900, the effect of high frequency "scintillation" under the form of sparks and effluves is to eliminate the neoplastic tissues and to stimulate the tropho-neurotic curative action of the underlying healthy layers. The work of repair is undoubtedly the one I have indicated (a selector of the underlying healthy layers). sclerogenous processus which fills up rapidly the deficiencies caused by loss of substance, and thus leads to an excellent cicatrix being left).

(4) High frequency "scintillation" is sufficient for

superficial epitheliomata which are accessible to the electrodes; the knife should only be brought into play for large tumours and for those which are very deeply seated.

(5) In superficial epitheliomata, short or long effluves and the smallest sparks are sufficient to destroy the pathological elements and to stimulate the healthy tissues during their work of repair; with reference to other cases of malignant growths, it may be necessary, according to circumstances, to have recourse to more or less lengthy sparks and effluves, and to electrodes of various forms, so as to be able to localise the scin-

(6) Fulguration of the operation wound can be done either with sparks or with effluves; the former are necessary to complete an operation which has been acknowledged by the surgeon to be incomplete; the latter I consider sufficient and even preferable in cases where the operation has been deemed complete and

(7) In all cases, the seat of the operation should be submitted from time to time to high frequency effluvation so as to prevent recurrence.

#### SOME RECENT RESEARCHES

ON THE

#### FUNCTION OF THE NON-AUDITORY EAR.

By R. H. WOODS, M.B., F.R.C.S.I., Surgeon for Throat, Nose and Ear to Sir Patrick Dun's Hospital, Dublin.

I must first express my indebtedness to the works of Crum Brown, Alexander, Barany, Neumann, and others for much of the subject-matter of the following paper.

In determining the function of the non-auditory part of the ear, we are met at the outset with the difficulty that it does not communicate with the cortex of the brain, as do our other sense-organs. To discover the function of the eye, we have only to close our lids, and its use for sight is at once apparent; similarly by stopping the ear its acoustic function is disclosed. stopping the ear its acoustic function is disclosed. Our information concerning the labyrinth must, therefore, be derived from its indirect effects on other parts of the body; in other words, by its reflex phenomena. The internal ear, or labyrinth, is, roughly speaking, composed of three parts. The cochlea, in which is contained the end-organ of hearing; the vestibule, in which lie the eacoustic and strictly and the semi-

which lie the sacculus and utriculus; and the semi-circular canals, in which lie the membranous canals of the same name.

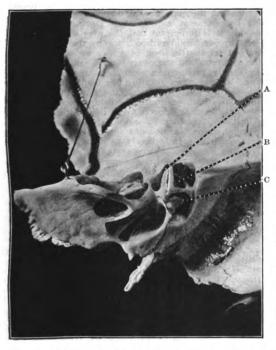


Fig. 1.-Dissected right temporal bone seen from above, behind and within.

A. Superior canal. B. External canal. C. Posterior canal.

There are three semi-circular canals, each occupying planes at right angles to the other two. Two are vertical, the anterior and posterior; the third lies horizontally. The two vertical canals make (as already mentioned) an angle of 90 with one another, and they are so placed that each makes an angle of 45° with the mesial plane. It will thus be seen that the plane of the anterior canal of one side is parallel with that of the posterior canal of the opposite side, while the horizontal canals are in the same plane.



Fig. 2.-Cast of left internal ear.

A. Ampulla of superior s.c. canal. B. Ampulla of horizontal canal. C. Ampulla of posterior canal.

Each canal is furnished at one end with a dilatation called an ampulla. The ampullæ of the superior and horizontal canals lie quite close together, and in immediate relation to the junction of the second and third stages of the facial nerve, by which they are separated from the fenestra ovalis. The ampulla of the posterior canal lies deeply at the lower end of the vestibule, where the lower end of the posterior canal enters it. The superior and posterior canals have a short portion common to both at the ends removed from their ampullæ.

In the bony labyrinth, and roughly corresponding to it, lies the membranous labyrinth. Contained in the bony semi-circular canals, and of similar shape, lie the much smaller membranous canals. These are attached by their convexities to the lining membrane of the bony canals, and all three open by both ends into one of a pair of membranous sacs which lie side by side in the vestibule. This sac is called the utriculus. The utriculus is connected by a fine duct with the other vestibular sac, the sacculus, and this is in turn connected with the membranous canal of the cochlea.

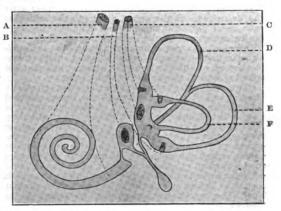


Fig. 3.-Diagram of the left membranous labyrinth.

A. Cochlear portion of VIIIth nerve. B. Portion distributed to the saccule and posterior ampulla.

C. Portion for the utricle and superior and horizontal D. Superior canal. E. Posterior canal. ampullæ. F. External canal.

Each membranous canal has a dilatation or ampulla corresponding with that of its bony canal. Each ampulla has a tiny crest, formerly called the crista acoustica, because its function was supposed to be an auditory one, but now named the crista ampullaris.

Each crista is supplied by filaments derived from the vestibular portion of the auditorv nerve, and from the cells of the crista delicate hair processes are joined together by some colloid material to form a small cap called the cupula. Each cupula projects a little beyond the middle of its ampulla.

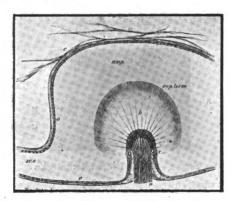


Fig. 4.—Semi-diagrammatic illustration of a membranous ampulla showing cupula (Schäfer).

On the walls of the sacculus and utriculus respectively are two patches of aggregations of cells, the maculus utriculi and the maculus sacculi. From these cells similar hair processes extend into a colloid material, in which are embedded crystals of calcium carbonate. One division of the estibular portion of the auditory nerve is distributed to the sacculus and the posterior ampulla, while the other goes to the utriculus and anterior and horizontal ampullæ. The central termination of the vestibular nerves is in the medulla in relation to Deiter's nucleus, from which filaments go upwards to the oculomotor nuclei and downwards to the anterior horns of the cord. The former are believed to be the path through which the eye reflexes travel, while through the latter are conveyed those impulses which influence equilibrium.

The first experimenter on the function of the semicircular canals was Flourens. He showed on pigeons that whenever any canal was destroyed, movements of the head, body, and eyes in the plane of that canal took place. This is called Flourens' law.

In order to explain the occurrence of movement after the destruction of the organ, Flourens assumed that each canal normally exercised an inhibitory influence on the movements of the body in its own plane.

Goltz, in 1870, put forward the theory that the semicircular canals were an organ to assist in the maintenance of equilibrium, and his opinion was that the stimulus worked through hydrostatic pressure.

Since that time, many investigators, but especially Breuer, and Mach, and Crum Brown, have explored this obscure region. As a result of their labours, it is now believed that the function of the vestibulary apparatus is to give a response to every change in our state as regards movement, whether in right lines, curves, or rotation. They hold that the semi-circular canals convey information with regard to any change in the angular velocity of rotation, while the function of the maculæ is similarly to convey information with regard to change in velocity of the body in a straight line. The mechanism, according to them, is as follows:—

The two maculæ are furnished with crystals of calcium carbonate, so-called statoliths, on the ends of their hair processes. When the head moves in any direction there is a tendency, owing to their inertia, for these statoliths to lag behind; this lagging is felt by the hair processes as a push or a pull according to the direction of the movement. And since the maculæ are situated at right angles to one another, any movement in the horizontal plane must have a corresponding reaction from one or both maculæ. It follows from this that, once movement in a straight line has become uniform, no information is conveyed as to the direction of that movement: the whole labyrinthine system must

be at rest with regard to itself, and hence no impression is carried. Everyone has tried the childish experiment of closing the eyes during a railway journey and imagining that the train is going in the opposite direction.

It is said that birds and fishes have three maculæ, the reason being that they move in three dimensions, while ordinary animals are confined to two. Whether this is the case or not, man is certainly not without a sense of his movement in the up and down direction, as anyone who has ever been in a lift or at sea can testify; but whether the information of that movement is conveyed by the labyrinthine apparatus may well be open to question; it may easily be furnished by increased or diminished pressure on the soles of the feet, and perhaps by variations in pressure of the contents of the stomach on its floor, at the beginning and end of the movement.

In the same way that the soles of the feet may convey information as to up and down movement, the skin on other parts of our body may help us in perceiving acceleration or retardation in right lines when we sit in a moving vehicle; but, even allowing for all this, there seems to be room enough left for the macula to be useful in connection with movements of various parts of the body with relation to one another, whether of the head to other parts, or of other parts to the head. Such a sense, to be useful, must be intimately bound up, as of course it is, with the muscular sense.

Their view of the semi-circular canal mechanism is as follows: When rotation begins, say, in the horizontal plane, the inertia of the endolymph causes it to lag behind. A relative current is set up in the horizontal canal in the opposite direction to the body movement. The effect of this current is to move the cupula of the crista ampullaris, and this movement constitutes the stimulus whereby we become aware that rotation has started, and whereby the important eye reflexes already referred to are liberated. An interesting and simple experiment in this connection may be made by closing one's evelids and gently laying the pulps of the fingers on them. If now we suddenly turn on our heel, the eyeballs may be felt to move or twitch from side to side horizontally under the fingers, the twitching being quicker in the direction of the body movement than in the opposite one. The reason for such a thing happening is easily seen. During rotation of the body it is important that the eyes should fix the objects in our neighbourhood, for by this fixation we learn our relation to them in a way we could not do if the eyes remained stationary in the head, and passing objects only produced a blurred impression on the retina. Hence, when rotating our bodies, say, to the right-i.e., in the direction of the hands of a clock lying on its back-the eyes lag behind looking at or fixing neighbouring objects until they get too far to the left for comfort. The eyes then make a quick movement in the direction of rotation, and fix a second point, which in turn is slowly followed back, and so on. Thus the eyes, during rotation of the body, undergo a series of quick movements in the direction of rotation, alternating with slow ones in the opposite direction. This is called nystagmus. Now, this nystagmus, which, on account of being quick in one direction and slow in another is called rhythmic. is, as we shall see, a pure labyrinthine reflex, and has for its exciting cause distortion of the cupula by the endolymph. It must be distinguished from that variety which is found as a congenital defect in Albinos, and as an acquired one in certain diseases of the eye, and consists of oscillations of equal rapidity in both This latter is therefore called undulatory directions.

Vestibular nystagmus is always increased by looking in the direction of the quick movement, and diminished by looking in the opposite direction, and this gives us a ready means of estimating its degree.

a ready means of estimating its degree.

It is said to be of the first degree when it is only evoked by looking in the direction of the quick movement. The second is where it exists while the patient looks straight forwards, and the third is where it is not suppressed when looking in the opposite direction. Mach and Breuer hold that the immediate cause of this rhythmic nystagmus, therefore, is distortion of

the cupula of the crista by the endolymph. Thus, in starting horizontal rotation to the right round a vertical axis, a current is set up in the right horizontal semi-circular canal, which tends to distort the cupula away from the canal, and towards the utricle, and the effect of this distortion is horizontal nystagmus to the right. Again, when rotation has been uniformly continued for some time, the endolymph partakes of the general movement of the labyrinth, the cupula reverts by its elasticity to its normal position, and the system is brought to internal rest. If now the rotation is stopped, movement of the endolymph is, by virtue of

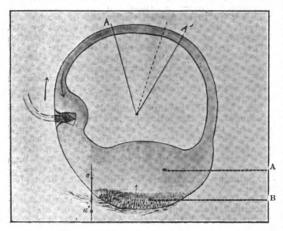


Fig. 5.—Diagram of semi-circular canal and utricle. A. Utricle. B. Masculus.

its inertia, once again started, the movement being in the direction of rotation—that is, relatively opposite to its first movement. The cupula is therefore distorted in the opposite direction (inclining in the right ear towards the canal), and nystagmus in the opposite direction takes place. Thus, during right rotation, nystagmus to the right takes place, and when rotation stops we get the "after" nystagmus in the opposite direction—viz., to the left. For convenience this after nystagmus is the only one observed, and it is used to measure the effect of rotation on the labyrinth, and therefore its irritability.

(To be concluded in our next.)

#### OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

GASTRO-ENTEROSTOMY.—MR. A. CARLESS operated on a middle-aged woman who had been for years the subject of gastric ulcer. The usual remedies and dieting had been more or less effective, but she was unable to take solid food, and every now and then her symptoms-sickness and pain-became urgent. There was some tenderness in the epigastrium on palpation, but the patient was a little indefinite as to whether the spot of maximum tenderness was in the middle line or a little to the right of it. There was some history of loss of blood by the bowel, but it was There was some doubtful as to whether it was a true melæna. Hæmatemesis had never occurred. On examination the patient's nutrition was fairly good; there was no evidence of gastric dilatation. It was obviously a case in which gastro-enterostomy might be expected to be beneficial. The operation was conducted in the usual way through a median incision externally just below the umbilicus. The stomach was examined, and some evidence of kinking found in the neighbourhood of the pylorus. On turning up the transverse colon and dividing the transverse meso-colon it was found that adhesions were present between the posterior wall of the stomach and the peritoneum covering the pancreas, and a little ingenuity was required to secure a suitable portion of the posterior gastric wall for establishing the anastomosis. The upper portion of the jejunum was then found, and clamped together with the stomach by Robson's clamps. Openings of one inch and three-quarters were made in each of these viscera, and the artificial communication established by two rows of sutures—front and back, silk being the material employed. A few of the larger vessels in the walls of the stomach were secured by passing a suture beneath them and tying. One or two stitches were also introduced between the jejunum and the stomach to the right of the anastomosis in order to maintain the direction of the jejunum and prevent kinking. The parts were subsequently replaced, and the abdomen closed in the usual way.

Mr. Carless pointed out that considerable importance must be attached to the direction in which the incision in the stomach is made; if it be made so that when the stomach is replaced the long axis of the communication is directed from below, upwards, and to the right, it is more likely that the jejunum below the communication will become kinked, and "vicious circle" vomiting of bile established. It is desirable, he said, that in gastro-enterpstomy the direction of the long axis should be from above, downwards, and to the right, so that the jejunum passing onwards has no sudden alteration in its direction.

PADDINGTON GREEN CHILDREN'S HOSPITAL. ARTHRECTOMY OF KNEE-JOINT. — MR. ARTHUR EDMUNDS operated on a girl, æt. 8, who had been under observation for three years. The disease manifested itself by wasting of the limb, thickening of the synovial membrane, and a certain varying amount of fluid in the joint. At no time did the patient have pain of any consequence. Complete rest, followed by ambulatory treatment with a Thomas's knee-splint, had been carried out during the whole time when under observation, the diagnosis being synovial tubercle of the knee-joint (a point which was confirmed by the operation). The child's surroundings were none too favourable for treatment, and there was reason to believe that medical orders were not carried out at home; at any rate, the condition did not ameliorate, and it was felt that it would be advisable to perform an operation. Operations on tuberculous joints, Mr. Edmunds said, although extremely satisfactory from the point of view of removal of disease, leave much to be desired as regards the functions of the joint and the growth of the limb, especially in young children. Fortunately, in these cases non-operative measures are very successful, and although a large number of these have been introduced, the essential points remain the same—namely, rest and fixation of the joint; and, with the increasing facilities provided by various philanthropic agencies for keeping children at the seaside for long periods, arthrectomies are becoming much less frequent operations. The degree to which recovery can take place is often very complete, a slight limitation of movement and muscular atrophy being the only indications of the disease which persist. Any surgical operation will almost certainly be followed by deformity of the joint, or, in the case of the knee, by considerable limitation of movement and shortening; it is for this reason that in the present case a prolonged trial was given to non-operative measures before attempting to remove the diseased portions.

A large U-shaped flap of skin was turned up in front of the knee-joint, its upper limbs extending to the upper limit of the synovial membrane (a tourniquet was applied before the incision was made); the patella was then sawn across, and the quadriceps extensor reflected until the limits of the synovial membrane were reached. The thickened pouch in front of the femur was dissected off the bone, and then the whole of the synovial membrane of the joint excised in one piece; the crucial ligaments were divided so as to gain access to the posterior part of the joint, but a few fibres of the lateral ligaments were saved, so as to give lateral stability to the joint. In one or two places there was superficial infection of cartilage, and here the affected portions were cut away. The wound was washed out thoroughly, the patella wired, and a drainage tube inserted to allow any blood to run away, and the wound closed.

The child had very little pain after the operation, and ten days afterwards everything was completely

healed with the exception of the opening for the drainage tube, which latter had been removed after 48 hours.

#### SPECIAL REPORTS.

#### GENERAL MEDICAL COUNCIL.

EIGHTY-NINTH SESSION.

FOURTH DAY.-FRIDAY, MAY 28TH, 1909.

The President, Sir DONALD MACALISTER, in the Chair.

THE minutes of the last meeting were taken as read and confirmed.

The following official intimation of the appointment

of a member of the General Council :-

We, the Council of the Victoria University of Manchester, in pursuance of the power given to us by the Medical Act (1886), do hereby appoint John Dixon Mann, M.D., F.R.C.P., to be a member of the General Council of Medical Education and Registration of the United Kingdom, for the term of two years from the 12th day of May, 1909.
F. FORBES ADAM, Chairman of Council.

ALFRED HOPKINSON, Vice-Chancellor.
(On behalf of the Council.)

The following were elected as members of the stated

Committees:

Examination Committee.—English Branch Council: Drs. Taylor, Saundby and Caton. Scottish Branch Council: Sir Thos. Fraser, Drs. Finlay and McVail. Irish Branch Council: Sir John Moore, Sir Chas. Ball, Dr. Kidd.

Education Committee .- English Branch Council:

Education Committee.—English Branch Council:
Dr. Norman Moore, Sir G. Philipson, Sir John
Williams. Scottish Branch Council: Dr. Mackay,
Mr. Hodsdon, Dr. Knox. Irish Branch Council:
Sir Thos. Myles, Sir C. Nixon, Dr. Little.
Public Health Committee.—English Branch Council:
Dr. Cocking, Mr. Power, Dr. McManus. Scottish
Branch Council: Dr. Norman Walker, Sir John
Tuke, Dr. McVail. Irish Branch Council: Sir John
Moore Dr. AdvecCurran Dr. Kidd Moore, Dr. Adye-Curran, Dr. Kidd.

Pharmacopaia Committee.—The President, Chairman; Drs. Norman Moore, Barrs, Little, Caton and McVail, Sir John Moore, Sir G. Philipson, Sir Thos.

Fraser.

Finance Committee.—Mr. Tomes, Chairman; Mr. Morris, Sir John Tuke, Dr. Little.

Dental Committee.—The President, Chairman; Mr.

Morris, Mr. Tomes, Mr. Hodsdon, Sir Thos. Myles. Denial Education and Examination Committee.— Mr. Tomes, Chairman; Mr. Morris, Drs. Knox and Finlay, Sir Thos. Myles, Sir Chas. Ball.

riniay, Sir Thos. Myles, Sir Chas. Ball.

Students' Registration Committee.—Sir Hugh
Beevor, Chairman; Drs. Norman Moore, Mackay, and
Adye-Curran, Sir J. Batty Tuke, Sir Ch. Nixon.

Moved by Sir Hugh Beevor, seconded by Dr.
LITTLE, and agreed to:—"That Mr. H. Stansfield
Collier, F.R.C.S.Eng., be appointed Assistant
Examiner in Surgery to the Apothecaries Society of
London, vice Mr. McAdam Eccles, who retires by
rotation."

Moved by Dr. Norman Moore, seconded by Sir John Moore, and agreed to:—"That the report from the Pharmacopæia Committee be received and entered

in the minutes."

Moved by Sir Hugh Beevor, seconded by Dr. Norman Moore, and agreed to:—"That the report from the Students' Registration Committee be received,

entered in the minutes, and approved."

On motion from the Chair it was resolved:—"That the report from the Finance Committee be received and entered in the minutes."

Moved by Dr. McVall, seconded by Dr. Caton, and agreed to:—"That the report from the Examination ommittee on the returns as to examinations for the

Moved by Dr. McVail, seconded by Sir Christopher Nixon, and agreed to:—"That the table showing results of a competition held in May, 1909, for com-

missions in the Royal Navy be received and entered in the minutes.'

Moved by Dr. McVail, seconded by Sir Christopher Nixon, and agreed to:—"That the thanks of the Council be conveyed to the Director-General of the Navy Medical Service for the returns which he has again furnished to the Council, with the request that these returns may in the future continue to be furnished to the General Medical Council."

Moved by Sir John Moore, seconded by Dr. Norman Moore, "That the report from the Public Health Committee be received, entered in the minutes, and approved." After a discussion with reference to reducing by three months the period of compulsory study for the M.O.H., an amendment moved by Mr. Thomson, seconded by Sir Christopher Nixon, "That the report be referred back to the Public Health Committee for re-consideration," was lost; the original motion was then put and carried.

Strangers then withdrew in order that the Council might receive in camerá, a report by the Executive

Committee.

The Council having resumed, announced that the following had been elected memannounced that the following had been elected members of the Executive Committee:—Dr. Norman Moore, Sir Hugh Beevor, Mr. Tomes, Dr. Langley Browne, Sir John Tuke, Dr. McVail, Sir John Moore, Sir Charles Ball; and that the following had been elected members of the Penal Cases Committee:—Dr. Saundby, Mr. Tomes, Dr. Finlay, Sir Christopher Nixon.

Council then resumed the consideration adjourned from November 27th, 1908, of the facts proved against William John Watson. On May 24th, 1909, the Dental Committee had drawn up a supplementary report which ended by stating that "the committee cannot regard the evidence presented by W. J. Watson as to his conduct in the interval as satisfactory."

Mr. Watson attended in answer to his notice. He

was not accompanied by counsel or solicitor. The British Dental Association, the complainants, were represented by Mr. R. W. Turner, their counsel, instructed by Messrs. Bowman and Curtis-Hayward, solicitors.

The Registrar having read the report, leave was accorded to Mr. Watson to address the Council, which

Mr. Turner having also spoken, the Council deliberated on the case in camera. Strangers having been re-admitted, the President announced the judgment of the Council as follows:—Mr. Watson, the Council has again given careful consideration to the two reports of the Dental Committee, and has deferred the further consideration of your case to November next, when you will be required to be present in person and to produce satisfactory evidence, and not merely a personal statement, as to your professional good conduct in the interval, with particular reference to your undertaking to discontinue all advertising, or connection, direct or indirect, with those who are advertising.

The Council resumed the consideration adjourned from November 27th, 1908, of the facts proved against Charles Morgan in regard to whom the Dental Committee, at its meeting on Monday, May 24th, 1900, drew up a supplementary report, stating inter alia that C. Morgan still continued to advertise on the curtain of the Empire Theatre, Newport.

Mr. Morgan attended in answer to his notice, accompanied by Mr. Arthur P. Poley, his counsel, instructed by Mr. H. Morgan Rees, solicitor, of

The complainants, the British Dental Association, were represented by R. W. Turner, counsel, instructed by Messrs. Bowman and Curtis-Hayward, solicitors.

The Registrar having read the report, Mr. Poley sought and obtained leave to address the Council on the report. He read a letter from the Secretary of the London and Provincial Advertising Agency, Limited, consenting to withdraw the advertisement from the curtain at the Empire Theatre, Newport, on certain terms, and asked that the Council would post-pone judgment in order that Mr. Morgan might have an opportunity to show that this had been done.

Mr. Turner did not desire to offer any observations

The Council deliberated on the case in camerá, and strangers having been re-admitted, the President announced the judgment of the Council to be as

Mr. Morgan: The Council has again given careful consideration to the reports of the Dental Committee, and has deferred the further consideration of your case to November next, when you will be required to be present and to offer satisfactory evidence other than your own statement as to your prcfessional good conduct in the interval, with particular reference to your promise to discontinue the issue, direct or indirect, of all advertisements.

The Council resumed the consideration of the report of the Dental Committee on the charge against Samuel David Davis, of Wisbech, Cambs., of acting as dentist and general assistant to a Dental Company at Wisbech, none of the directors or shareholders of which are registered dentists, and unregistered persons, being in its employ.

The Registrar having read the report, Mr. Davis sought and obtained leave to address the Council on

the report, which he did.

Mr. Turner did not desire to address the Council in reply on the part of the British Dental Association. Strangers having been re-admitted, after the Council had deliberated in camera, the President announced the decision of the Council as follows:—

Mr. Davis, I have to inform you that the Council has given careful consideration to the report of the Dental Committee, and that they have judged you to have been guilty of infamous and disgraceful conduct in a professional respect, and have directed the Registrar to erase from the Dentists' Register the name of Samuel David Davis.

The Council proceeded to the consideration of the report of the Dental Committee on the charge against Frederick Joseph Whitehead, of Wisbech, Cambs.

The complaint was the same as against S. D. Davis, and had reference to the same company and the same unregistered persons.

Mr. Whitehead did not attend, nor was he repre-

The complainants, the British Dental Association, were represented by Mr. R. W. Turner, counsel, instructed by Messrs. Bowman and Curtis-Hayward, solicitors.

The Registrar having read the report, Mr. Turner, on question from the Chair, intimated that he did not desire to address the Council.

The Council then deliberated on the case in camera. Strangers having been re-admitted, the President announced the judgment of the Council as follows:—
Mr. Turner: I have to announce that the Council

have given careful consideration to the report of the Dental Committee, and have judged Mr. Frederick Joseph Whitehead to have been guilty of infamous and disgraceful conduct in a professional respect, and have directed the Registrar to erase from the Dentists' Register the name of Frederick Joseph Whitehead.

The Council proceeded to the consideration of the report of the Dental Committee on the charge against Reuben Davis, whose present address was Boston, U.S.A., and who had been convicted in England on three separate occasions of larceny.

Mr. Reuben Davis did not attend in answer to his

notice, nor was he represented by counsel or solicitor.

The Registrar read the report of the Dental Committee, and after the Council had deliberated in camerá, and strangers having been re-admitted the President announced the judgment of the Council as follows :-

I have to announce that, it having been proved that Reuben Davis has been convicted of various misdemeanours as set forth in the report of the Dental Committee, the Registrar has been directed to erase from the Dentists' Register the name of Reuben Davis.

The Council proceeded to the consideration of the report of the Dental Committee on the charge against Stanley Bennett Wakefield, who had been convicted at the Marlborough Street Police Court of illegal pawning, and who had also made a false and fraudulent claim.

Mr. Wakefield did not attend in answer to his

notice, nor was he represented by counsel or solicitor.
The complainants, the British Dental Association, were represented by Mr. R. W. Turner, counsel, instructed by Messrs. Bowman and Curtis Hayward, solicitors.

The Registrar having read the report, Mr. Turner, in answer to a question from the Chair, stated that he did not desire to address the Council on the report.

Strangers having been re-admitted after the Council had deliberated in camera, the President announced the decision of the Council as follows:—

I have to announce that, it having been proved that Stanley Bennett Wakefield has been convicted of a misdemeanour, the Registrar has been directed to erase from the Dentists' Register the name of Stanley Bennett Wakefield.

The Council proceeded to the consideration of the report of the Dental Committee on the case of Thomas Parkins, of Salford, Manchester, who had allowed part of his practice as a dentist to be carried on at Sharrow Head House, Sheffield, by his son, Charles Henry Parkins, an unregistered person.

The Registrar having read the report, Mr. Parkins addressed the Council, and Mr. Turner replied for

the British Dental Association.

Strangers having been re-admitted after the Council had deliberated in camera, the President announced the decision of the Council as follows:

Mr. Parkins: I have to inform you that, upon the facts found in the report of the Dental Committee, the Council have judged you to have been guilty of infamous or disgraceful conduct in a professional respect, and have directed the Registrar to erase from the Dentists' Register the name of Thomas Parkins.

Strangers by direction from the Chair again with-drew, in order that the Council might consider a

matter in camera.

On strangers being re-admitted, the Council proceeded to the consideration of the case of Thomas Torrens McKendry, registered as of 30 Wellwood Road, Goodmayes, Ilford, Essex, M.B., Bac. Surg., 1894, R. Univ. Irel., who has been summoned to appear before the Council on the following charge a: formulated by the Council's solicitor:-

"That you have knowingly and wilfully on various occasions, and in particular on the 20th day of February, 1909, assisted one E. C. Dalby, a person not registered as a dentist, in carrying on practice as a dentist by administering anæsthetics on his behalf to persons coming to him for treatment, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainant was Mr. Victor Albert Chatelain.

Mr. McKendry attended in answer to his notice. He was not accompanied by counsel or solicitor. Mr. Chatelain, the complainant, attended in person, without counsel or solicitor.

The Council's solicitor having read the notice, Chatelain proceeded to open his case. He called Mrs. Florence Jane Chatelain as a witness, and examined. the Mr. McKendry did not desire to cross-examine the witness. He called Mr. William Raymond Bryan as a witness, and examined him. Mr. McKendry did not desire to cross-examine the witness, who answered questions put to him by the Legal Assessor. Mr. Chatelain read a declaration by Mr. Richard Henry Stevens, L.D.S., R.C.S., Eng., a registered dentist of Ilford, which he put in. He next called Mr. Joseph Bethel Cox, a registered medical practitioner, of Seven Kings, as a witness and examined him. He was cross-examined by Mr. McKendry, and answered questions put to him by the Legal Assessor.

Mr. Chatelain then made a statement by way of evidence, and was cross-examined by Mr. McKendry.

Mr. McKendry then addressed the Council on his own behalf, and tendered his statement as part of the evidence for the defence. He was cross-examined by Mr. Chatelain. Mr. McKendry also answered questions put to him by the Legal Assessor.

Mr. McKendry called Mr. Henry Charles Dalby as

a witness, and examined him. He was cross-examined by Mr. Chatelain, and re-examined by Mr. McKendry.

He also answered questions put to him by the Legal

[Moved by Dr. NORMAN MOORE, seconded by Dr. LITTLE, and agreed to :—" That the Council meet at ir o'clock a.m. to morrow in order to deal with the remaining items on the programme of business.

Mr. Chatelain then addressed the Council in reply. Strangers and Mr. McKendry having been re-admitted after the Council had deliberated in camera, the President announced that the Council had found that the facts alieged in the notice of inquiry had been proved to the satisfaction of the Council.

Mr. McKendry gave his assurance that he would not again transgress against the resolution of the for unregistered dentists, and expressed his regret that he had done so on several occasions.

Strengers then withdrew in order that the Council might consider its judgment. Strangers having been re-admitted, the President announced the decision of the Council as follows:—

Mr. McKendry: The Council has postponed judgment till the November session, when you will be required to attend in person and to produce evidence, more particularly from medical colleagues in your neighbourhood, as to your professional good conduct generally in the interval, and in particular that you have not repeated the offence of which complaint has been made.

The Council proceeded to the consideration of the case of Robert Galbraith Reid, registered as of 202, Ewell Road, Surbiton, formerly of 176 Lambeth Road, S.E., M.B., Mast. Surg., 1887, Univ. Glasg., who had been summoned to appear before the (ouncil on the following charge as formulated by the Council's solicitor :-

That you abused your position as a medical man by having sexual intercourse with one Annie Wahl when you were in her house at 31, Stangate Street, Lambeth Road, S.E., as a medical man professionally attending her husband, Joseph Wahl, and by sub-sequently attempting to have sexual intercourse with her, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainant was Mrs. Annie Wahl

Mr. Reid attended in answer to his notice, accompanied by Mr. Forrest Fulton, his counsel, instructed by Mr. Arthur Giles, his solicitor.

Mrs. Wahl attended in support of her complaint, accompanied by Mr. Vaughan Whitehead, her solicitor.

Mr. Whitehead opened the case for Mrs. Wahl, and called her as a witness, and commenced his examination-in-chief.

Six o'clock having arrived, the Council adjourned.

#### FIFTH DAY.-SATURDAY, MAY 29TH, 1909.

The President, Sir DONALD MACALISTER, in the Chair,

THE whole of the day was taken up by the consideration, adjourned from Friday, May 28th, of the case of Robert Galbraith Reid, M.B., M.S., Univ. Glasgow.

Mr. Whitehead continued his examination-in-chief of Mrs. Wahl, the complainant. She was then severely cross-examined by Mr. Forrest Fulton, and questions put to her by the Legal Assessor.

Mrs. Elizabeth Bailey, Mrs. Wahl's mother, was next examined by Mr. Whitehead, and cross examined by Mr. Forrest Fulton.

Mr. Wahl, husband to Mrs. Wahl, was then

examined by Mr. Whitehead, cross-examined at some length by Mr. Forrest Fulton, and re-examined by Mr. Whitehead. He also answered questions put to him by the Legal Assessor.

Mrs. Annie Westen was examined by Mr. Whitehead, cross-examined by Mr. Forcest Fulton, and re-

examined by Mr. Whitehead.

At six o'clock the President announced that a Committee had been formed to consider the subject of Annesthetics, and to report on this question to the Council at the November session.

The Committee consisted of:—The President, Mr.

Morris, Mr. Tomes, Mr. Hodsdon, Sir Charles Ball, Dr. Knox.

The Council then adjourned.

#### SIXTH DAY .- TUESDAY, JUNE 1ST, 1909.

#### The President, SIR DONALD MACALISTER, in the Chair,

On strangers being re-admitted after the Council had considered certain matters in camera, the minutes of the last meeting were taken as read, and confirmed. The Council resumed the consideration, adjourned from Saturday, May 29th, 1909, of the case of Robert G. Reid, M.B., M.S., Univ. Glasgow.

The President informed the parties that the Council had decided to sit that day, with the usual intervals, so long as might be necessary to finish the hearing of

Mr. Whitehead called Isabella Mitchell and by examined her. The witness was cross-examined by Mr. Forrest Fulton, re-examined by Mr. Whitehead, and answered questions put by the Legal Assessor. Mr. Whitehead's other witnesses not having arrived, the ordinary business of the Council was proceeded with.

Moved by Dr. NORMAN MOORE, seconded by Mr. THOMSON, and agreed to:—"That the report from the Dental Education and Examination Committee be received and entered on the minutes." The report had reference to a letter received from an educational body, the Incorporated Dental Hospital of Ireland, calling attention to a certain difference existing between the requirements of the several bodies granting licences in dental surgery-viz., with regard to the year or years of bond fide apprenticeship with a registered dental practitioner.

Moved by Mr. Morris, seconded by Sir Chas. Ball.

and agreed to:—"That the Report of the Denta!
Education and Examination Committee be communicated to the R.C.S.Eng. for such observations as that body may be inclined to offer. The case of R. G. body may be inclined to offer. The case of R. G. Reid was then proceeded with.

Mrs. Amelia Nicholls was examined by Mr. White-

head and cross-examined by Mr. Forrest Fulton.
W. Nicholls and Ernest Wahl were examined, cross-

examined, and re-examined, and answered questions put by the Legal Assessor.

Mr. Forrest Fulton then addressed the Council in defence of Mr. Reid. During his speech he traversed the evidence given against his client, and said that

if it were believed no doctor would be safe. He then called Mr. Reid and examined him. his examination-in-chief, he obtained permission from the Council to call Dr. Hector Mackenzie, who had been waiting for a long time, and examined him as to Mr. Reid's character Dr. Mackenzie was cross-examined by Mr. Whitehead.

Mr. Reid was then cross-examined by Mr. White-

head, and answered questions put to him by the Legal Assessor.

Mrs. Isabel Sophia Reid was next examined by Mr. Forrest Fulton, and answered questions put by the Legal Assessor.

As witnesses as to character Mr. Forrest Fulton called the Rev. Mr. Shepherd, Rector of Great Parnham, Essex, and formerly of Lambeth; the Rev. Mr. Hayes, Vicar of Holy Trinity, Lambeth; the Rev. Mr. Payne, Vicar of St. Andrews, Old Kent Road: Dr. Charles Sangster, of Lambeth; Mr. Honey, solicitor; Dr. S. M. Dowling, of Lambeth Road; Mrs. Lucy Langheimer, a nurse; Mrs. Wright and Miss Pearson, who had been employed as dispenser by Mr. Reid for two years

He also called Mr. Giles, solicitor, and examined im. The witness was cross-examined by Mr. White-

Mr. Whitehead then briefly addressed the Council. On strangers being re-admitted after the Council had deliberated in camera, the President addressed Mr. Reid as follows: The Council have come to the following resolution:—"That the facts alleged against you in the notice of inquiry have not been proved to the satisfaction of the Council."

Moved by Dr. NORMAN MOORE, and seconded by Dr. MACKAY:—"That the Report from the Education Committee on various proposals submitted to them referring to the curriculum in medicine be received and entered on the minutes."

An amendment, moved by Mr. Morris, and seconded by Mr. Thomson, "That the following words be added to the motion, 'and that it be circulated to the licensing bodies for their observations,'" was lost. The original motion was then put and carried.

Moved by Dr. Norway Mooney.

The original motion was then put and carried.

Moved by Dr. Norman Moore, seconded by Dr.

Finlay, and agreed to:—"That the consideration of
the Education Committee's Report be taken on the
first day of the November Session."

Moved by Dr. Norman Moore, seconded by Sir John
Moore, and agreed to unanimously. "That Mr. Allen

MOORE, and agreed to unanimously: "That Mr. Allen be appointed General Registrar of the Council till the

end of the summer session, 1910."

Moved by Dr. NORMAN MOORE, seconded by Mr. THOMSON, and carried by acclamation:—"That the best thanks of the Council be given to the President for his able services in the chair during the present session.

The Council then rose.

#### TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF ANATOMY AND PHYSIOLOGY.

MEETING HELD FRIDAY, APRIL 23RD, 1909.

The President, Dr. T. H. MILROY, in the Chair.

THE MECHANISM OF DEGLUTITION.

PROFESSOR W. H. THOMPSON made a communication on the above. He said the usual conception of the act of swallowing was that it consisted of three stages mouth, pharynx, and esophagus. But when one reflected it was obvious that the act was a reflex one, and, as such, would be discharged from certain places and by certain stimuli. It had been proved by ex-periment that the starting of the swallowing reflex was sufficient to carry the movement right down to the lower end of the esophagus, even though a segment of the esophagus were cut out, provided the nerves were retained intact. It is true, different conclusions on this point had been reached, but the divergences were explained by differences in the conditions of the experiments, such as depth of anæsthesia, etc. The same law had been shown to hold good in the human subject in a case of cervical esophagotomy, for when food was put in the lower segment of the esophagus it remained there until an act of swallowing was started from above, which travelled over the point of sever-ance and carried the bolus down. The areas from which the reflex could be discharged had also been investigated both in the lower animals and in man. The only thing necessary for the discharge was the contact of a properly prepared bolus with a definite spot of mucous membrane. After that the act was automatic. On further reflection it seemed rather unnatural to include in the act of swallowing anything prior to discharge of the reflex from the mechanical prior to discharge or the renex from the mechanical contact of the bolus with the defined area of mucous membrane. The act of swallowing would thus consist of two stages—(1) the stage immediately following the contact of the mucous membrane and the bolus, by which the latter was projected into the esophagus; and (2) the passage through the esophagus. Anything prior to these stages belonged to the preparation for swallowing, not strictly to the act itself. As regards the preparation, it was to be remembered that the pharynx, for the greater part of its time, was engaged in taking in air; it was only an occasional duty to perform the act of swallowing, and to safeguard the air passages from concomitant danger. The closure of the nose offered no difficulty; that of the larynx had also been satisfactorily explained, but the chief point of dispute present the plained; but the chief point of dispute concerned the part played by the epiglottis. It had been shown long ago that the epiglottis moves down in the act of swal-

lowing, but the investigations of Anderson Stuart somelowing, but the investigations of Anderson Stuart some sixteen to eighteen years ago pointed to a different conclusion. They were opposed at the time by Kanthack and Anderson, but the point remained unsettled. Recently a Dutch investigator, Eykman, had studied the movements of the epiglottis by Röntgen rays, and had shown that it did descend in swallowing, the free movements are the point of the bolus and carrying margin sweeping down behind the bolus and carrying on any fragments left behind. With regard to the propelling force, it had been stated by Kronecker and Metzer that the contraction of the mylohyoid muscles gave a starting thrust which was sufficient to shoot the bolus through the whole esophagus.

Professor Thompson showed the tracings on which the conclusions had been based, and considered that the conclusions had been based, and considered that they had been misinterpreted. It appeared to him that the proper explanation was that, on the moment of the discharge of the swallowing reflex, there was the discharge of the swallowing renex, there was started not merely a wave of contraction, but also a preceding phase of inhibition, to allow the easy passage of the bolus, and that this extended down into the esophagus for fully half its length. Such a condition of relaxation remained continuous in a series of acts of swallowing, as in the long esophagus of a horse, till the last act was discharged, when the larynx fell back and a wave of peristaltic contraction fol-lowed. A liquid bolus had not been traced farther than the region of the arch of the aorta in the human. subject. It was by no means shot down with the extreme rapidity originally supposed by Kronecker and. Metzer. With semi-solid and solid boluses, the mechanism was one of peristalsis practically the wholeway through. It seemed that the bolus often rested for a considerable period in the lower fourth of the peristaltic waves before an opening of the cardiac orifice of the stomach took place.

Professor Symington said it was difficult to realise.

that the tongue could move so extensively as to move the epiglottis in the manner described. In many animals the epiglottis normally extended upwards behind the soft palate. Certain animals had the upper opening of the larynx permanently fixed in the naso-pharynx, and the food must pass on one or other sides of it. In man there was no period in life in which they knew the epiglottis to project upwards. into the naso-pharynx.

Professor Dixon said it was not uncommon to find! space in the lower part of the esophagus containing food and liquor.

Dr. Johnston, Professor McWeeney, and the Presi-

dent also spoke, and Professor Thompson replied. CRITICAL SOLUTION POINT OF URINE.

Mr. W. R. GELSTON ATKINS gave a communication

on this subject.

Professor Thompson thought the method would work out of great value if it were reliable, as it was much-

more convenient than freezing.

The President said he wondered if the mean-arrived at would not vary very considerably under-experimental conditions. The great advantage of freezing was that it prevented alteration in the composition of the urine, while the molecular concentra-tion of urine altered during the process of warming.

Professor McWeeney said the method gave an tended scale and power to judge of very much smaller differences in molecular concentration, but until it had been tried under various conditions he did not think they could say much about it, as it depended on a number of factors which did not appear to have been fully investigated. EXHIBITS.

The President showed microscopic slides showing neuro-fibrillæ by Cajal's silver method.

Professor Dixon exhibited a drawing apparatus.

A SPECIAL meeting of the Council of the Charity A SPECIAL meeting of the Council of the Charity-organisation Society will be held on Monday, June-28th, at 4.30 p.m., at Denison House, Vauxhall Bridge-Road, S.W., when Miss Amy Hughes, of the Queen Victoria Jubilee Nurses' Institute, will read a paper on "Provident Nursing." Sir Alfred Lyall, G.C.I.E., K.C.B., will take the chair, and the Right Rev. the-Bishop of Islington will speak. NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD (IN LEEDS) MAY 21ST, 1909.

The President, Dr. J. W. MARTIN (Sheffield) in the Chair.

DR. E. O. CROFT (Leeds) showed the left kidney from a fatal case of

PYELITIS IN PREGNANCY. The patient died in coma a few hours after a series of three fits. She was six months advanced in her second pregnancy years before, and the labour had been followed by convulsions. The kidney was hydronephrotic, and contained a large quantity of milk-like pus. The dilated and thickened ureter contained caseous material. The right kidney was normal in size, and on naked-eye section showed evidence of slight fatty degeneration; its capsule stripped easily.

Dr. CROFT also showed a

LARGE, SOLID, BROAD LIGAMENT TUMOUR OF UNUSUAL CHARACTER.

It had been enucleated from the broad ligament of a woman, æt. 47, without injuring the corresponding tube and ovary. It weighed 141 lb., and measured 10 to 12 in. in various diameters. On section it showed a central well-defined oval mass, 5 or 6 in. in diameter, of the consistence of a soft uterine fibroid, and of a light brick red colour. This was surrounded by a broad band of material of a myxomatous appearance. From this area a considerable amount of fluid exuded. The tumour was apparently an odematous fibroid which had undergone central "red degeneration" and myxomatous degeneration of the peripheral portion.

Dr. Carlton Oldfield (Leeds) showed a speci-

men of

CARCINOMA OF THE CERVIX

which had been removed by Wertheim's method. The patient was only thirty years of age. She was also suffering from syphilitic rupia and ecthyma. One enlarged lymphatic gland was found in the parametrium close to the cervix.

Mrs. Orford (Pontefract) showed a specimen of

one-eyed monster (cyclo-cephalus).

Dr. J. B. Hellier read the notes of a case of DOUBLE UTERUS AND VAGINA, WITH UNILATERAL

HEMATOCOLPOS.

The patient, æt. 16, had menstruated regularly and normally for two years, with a little dysmenorrhæa.

For some months she had noticed a swelling at the ror some months see had noticed a swelling at the vulva, but only at the monthly periods. Retention of urine led her to seek advice. There was a normal vaginal passage leading to a normal cervix uteri on the left side. On the right was a cystic swelling occupying the whole length of the vaginal wall, and protruding from the vulva. On incising this about six ounces of dark red inspissated menstrual fluid but there was no sign of a hæmatosalpinx. The vaginal septum was completely excised. The patient has menstruated normally since.

Dr. HELLIER also showed a

UTERUS WITH DOUBLE PYOSALPINX.

The uterine body had been amputated because both thes and ovaries had to be removed. There was a tubes and ovaries had to be removed. septum extending to the os externum and completely dividing the uterus into two cavities.

#### EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD JUNE 2ND, 1909.

The President, Dr. JAMES RITCHIE, in the Chair.

A DISCUSSION on

EYE-STRAIN

was opened by Mr. GEORGE BERRY, who prefaced his remarks by saying that specialists, who were consultants, lacked the advantage of the general practitioner of being able to follow out the results of treatment, for in most cases they saw the patient only once or twice.

In the discussion which followed Mr. Berry's paper Dr. George Mackay expressed the opinion that part of the discomfort associated with astigmatism was due to ciliary action as well as to lid-pressure. While he did not as a rule use cycloplegics, he hought that they were cccasionally valuable in assisting at a complete study of the refractive error in difficult cases.

Dr. LYNE discussed the relation of ocular defect to migraine, and described some of the symptoms attributed to muscular imbalance. He agreed with Mr.

berry that the effects of slight divergence or convergence had been greatly overrated.

Dr. Sinclair pointed out that in many cases the symptoms of discomfort and headache produced by pypermetropia, etc., were temporary; if a patient were run down in health and suffered from these he might be relieved by wearing glasses, and as his health im-proved the glasses could again be dispensed with.

Dr. Main related some experiences in China, showing that among the Chinese prolonged exposure to the intense glare of the western sun was borne without any discomfert.

Dr. LUNDIE dwelt on the greater discomfort pro-

duced by the lesser degrees of error.

Dr. Thyne said that in his experience it was quite impossible to recognise any particular type of head-ache as specially associated with refractive error. He considered that in a case of headache if one failed to find any definite cause for it, the patient should at

once have the eyes properly examined.

In his reply, Dr. Berry said that the difficulty always was to foretell whether a given case would be improved by glasses, because one found that some individuals bore with no discomfort a considerable degree of refractive error, while others, with much less were greatly distressed by it. The nervous element had always to be taken into consideration.

Dr. ALEXANDER GOODALL read a paper on "A Pharmacological Study of the Value of Commercial Samples of Liquid Extract of Ergot, with notes on Ergot Standardisation." He pointed out that the present uncertainty regarding the chemistry of ergot renders standardisation necessary, and described the various methods in use. A number of tracings of the effects of various preparations on the blocd pressure and the uterus were demonstrated by means of the lantern.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 6th, 1909.

THE CAUSES OF DEPOPULATION IN FRANCE. CONTINUING his study of the causes of the depopulation in France, Prof. Courmont places, in the first rank, infantile mortality—that is to say, of children under one year old.

Theoretically speaking, there is no reason why a

child at that age, except under rare circumstances, should die. If it is of good constitution, as is generally the case, it can only succumb from some fault or imprudence on the part of the parents or those entrusted with its care. Possessing brand new organs, it can only die from some avoidable malady.

The mortality among infants in France is 15 per cent., representing a total of 120,000 infants per year. The mortality in England is 12 per cent., and in Norway and Sweden 8 per cent.

The principal maladies to which infants succumb in France are enteritis and affections of the respiratory tract. Six out of every ten deaths take place within

ten days after birth. The causes of the mortality might be traced to two principal origins: the quality of the milk and the care-

less treatment of children.

In nine cases out of ten the milk is responsible for infantile diarrhoea, and more especially where the child is bottle fed-contaminated milk, dirty bottles, dirty

For a child to be kept healthy it should be kept clean, and guarded against cold and contagious maladies (measles, scarlatina, diphtheria). The mother alone can assume the care of the children, and any derogation from these natural principles is due to neglect or imprudence.

The habit of placing children out at nurse, so general in France, is a great factor in infantile mortality. A child under one year cannot travel without serious risk, and it may be said that 50 per cent. of the children thus placed out do not attain their first

year.

As to the remedies against this useless infantile mortality, Prof. Courmont recommends the encourage-

ment of maternal nursing.

The well-to-do will not nurse, and the poor cannot. The former refuse the sacrifice from selfish motives, but the working classes cannot afford it, and for these the State should promote obligatory insurance, as is practised in Germany.

The production and sale of milk should be carefully controlled, and puericulture taught in the schools.

MORTALITY FROM TUBERCULOSIS.

Tuberculosis is the greatest plague of humanity, and yet it is one of the easiest to avoid. Any hope of stamping out the disease entirely is naturally absurd, but it is possible to reduce it by 50 per cent. at least.

In France about 150,000 deaths are due annually to that malady, and it might be affirmed that each year there are one million persons in France in whom tuberculosis is in a state of evolution, and yet what has been done against this decimating disease? Nothing.

During the course of the last century there were many great wars, and the shores were visited by cholera, and these calamities caused 21 million deaths. During the same period tuberculosis carried off from 10 to 15 millions.

The mortality per 10,000 inhabitants of large towns was calculated for 1905 as follows:—

31.80. ••• France ... ž6.99. Ireland ... ... ... ... Scotland ... ... 20.53. ... ... Germany ... 17.93. ... ... ... Italy ... England ... ... 16.94. ••• .. ... 16.30.

Thus the deaths from tuberculosis are double those

of England, Italy and Germany.

In order to understand the ætiology of tuberculosis, the seed and the soil should be considered. The seed can have both a human and an animal origin. The former comes almost exclusively from the expectora-tion, while the latter is, above all, bovine. Bovine tuberculosis is very general in France; in certain regions a quarter or a third of the animals are

The malady may be propagated through the meat, but the milk of tuberculous cows is the great efficient

Cause.

The Soil.—Man enjoys a certain immunity against

Broad where it has succeeded in the bacilli of Koch. Even where it has succeeded in penetrating the organism it is frequently encysted and No malady is more curable than tuberdestroyed. culosis, otherwise man would have long ago disap-

peared, decimated by the disease.

A healthy man, without hereditary taint, well nourished, well housed, ought to escape the disease; but numerous are the causes which weaken this relative immunity: heredity (predisposition), pregnancy, nursing, privations of all kinds, certain maladies (grippe), alcoholism, insalubrious dwellings, age (frequent under five years of age), and between 16 and 40, infrequent between 5 and 16. Tuberculosis is rare after 40 except in hard drinkers and persons suffering

from diabetes.

Until these last years the lungs were considered the natural entrance of the infection; the dust, penetrating with the inspired air, created primary tuberculosis of the lung. Prof. Courmont believes this idea to be erroneous, as the dust encounters great difficulty in entering the lungs, and when it overcobstacles, the lung defends itself efficiently. it overcomes all

For him, pulmonary tuberculosis is almost always secondary to infection of the ganglions, especially in

the chronic form. How do the ganglions become affected? Years ago Chauveau proved the facility with which the bacilli penetrate the digestive tract. According to Calmette, pulmonary tuberculosis is due to the ingestion of the bacilli of Koch (dust, milk, etc.).

Leseur and Courmont are of opinion that penetration is frequently effected in the child by the buccal mucous membrane, by sores on the head, by small cutaneous wounds, and the microbes go straight to the ganglions. In the dwelling of a tuberculous patient the child is frequently contaminated in this way; the flies carry the bacilli from the expectoration of the patient to the open sores of the child; tracheobronchic adenopathy is the consequence; later, consumption will follow.

ALOPECIA.

Doctors are frequently consulted for affections of the scalp, and more particularly for falling of the hair. The treatment of such cases requires to be well understood, for the success of the remedies used often depends on the manner in which they are applied. Before prescribing any treatment, says Prof. Brocq, it is necessary to elucidate one point often overlooked, and that is whether the scalp be dry or greasy.

A simple experiment suffices to remove any doubt. The patient is ordered to wash the head with soap and water, and after two or three days a piece of tissue paper is applied to the skin. If the scalp is dry, the paper is not stained; otherwise a greasy spot

is found at the point of contact.

Washing the head with soap and water is very useful in cases of seborrhoea; panama soap might be used or bran water in which the yellow of two or three eggs are beaten up in a pint of the liquid. This preparation is excellent for cleansing children's heads.

There is one agent much used at present which can render great service in certain cases—ether of petroleum. But great precautions must be taken in using it as it is so inflammable that it can take fire at a distance of two or three yards from a flame.

Consequently the patients should be warned never to use this preparation in a room with fire or light.

In intense seborrhea producing almost complete baldness, ether of petroleum is particularly useful. By alternating the ether frictions with a strong solution of formol, it is possible to provoke the growth of a fine down or even of adult hair after three or four months of the treatment.

If the scalp is dry, ether of petroleum should not be used as it may irritate the skin. Stimulant lotions such as the following might be prescribed:-

Tincture of jaborandi or cantharides, 1 oz. Soap liniment, 5 oz.

Hydrochl. of quinine, 15 gr. Hydrochl. of pilocarpine, 5 gr. Rum, 6 dr. Water, 4 oz.

In case of fair hair, proof spirit should take the place of rum, which might darken the colour.

Pityriasis of the scalp is best treated by one or

other of the following preparations:—
Lotions with liquid polysulphide of potassium, 30 to 100 drops for a quarter of a glass of hot water. The treatment should begin with 10 drops, and gradually increase until the limit of tolerance of the scalp is reached.

Two tablespoonsful of medicated coal tar to a glass of water meet the same end.

Liquid ammonia, 1 to 2 dr.

Rum, 4 dr.
Water, 4 oz.
To be applied with a soft tooth brush.

If the scalp is too dry, sulphur ointment might be used from time to time.

Precipitated sulphur, 2 dr. Cacao butter, 2 dr.

Castor oil, 2 oz. Peru balsam, r dr.

The ointment is applied at night and removed in the morning with soap and hot water, after which the extremities of the hair are gently rubbed with sweet

#### GERMANY. Berlin, June 6th, 1929.

A PAPER by Prof. A. Forel, quoted in the Deutsche Med. Zeitung, 34/09, deals with the TREATMENT OF EPILEPSY.

He says that all methods of treatment that have been lauded, with the exception of those by the bromine salts and abstinence from alcohol, have been lamentable failures. Wetterstrand claimed to have cured epileptics by suggestion; the writer is of opinion that the cases were really hysteria. The action of the bromine salts in epilepsy has long been known, but in general it has been so much misunderstood and used so wrongly by physicians, that it has fallen completely into discredit. Nearly all the epileptics that have consulted the writer have been wrongly treated. In the first place, experience has taught him that Charcot was right in recommending the three bromine salts, potash, sodium and ammonium in equal parts. But Toulouse had discovered the chief thing, viz., the substitution of the chloride of sodium in the system by the bromine salts, in order to obtain their effect. Formerly 6 to 10, and even 15 grammes had to be given to the adult, before the attacks ceased. If the chloride of sodium was kept back as much as possible very pronounced results were obtained with from 2 to 4 grammes pro die.

But practice has also taught us a number of other details. Above all, it has long been known that we must give the bromides in a very much diluted state, in order to avoid disturbances of digestion. Further, the bromides must not be given after mealtimes, as unfortunate chemical combinations are formed thereby; they must be given when the stomach is absolutely empty, half to three-quarters of an hour before food, so that they may enter the blood current in a highly diluted condition. In this way they are the most effective and cause the least disturbance. Further, we have to navigate between two rocks, between epilepsy on the one side and brominism on the other. The latter makes itself known chiefly by the acne and somnolence; such cases are to be watched carefully.

The bromide treatment frequently fails through want of perseverance on the part of both patient and physician. People are unnecessarily afraid of a bromide acne; or they imagine that they have done wonders when they have given 2 grammes of bromides for two or three months together without cutting off the salt at the same time. In reality they have done nothing at all. The attacks, that have been scarcely diminished, return worse than ever. The bromide treatment of epilepsy must be continued for years, and at least two years after the last attack has appeared

years after the last attack has appeared.

Finally, masked epilepsy and psychical epilepsy must not be confounded with ordinary epilepsy. In the two former, and especially in psychical epilepsy, the bromine salts have no effect, or, as frequently happens, a bad one; and in this form the writer has almost given it up. In masked epilepsy he has given them for some time, and occasionally has seen a good effect. For psychical epilepsy he knows no other form of treatment than the lunatic asylum, for the masked form abstinence from alcohol, life in the open air, bodily labour, and school discipline.

bodily labour, and school discipline.

In the borderland between epilepsy and grave hysteria, hypnotism and psychic analysis is to be recommended, they are the sovereign remedy for hysteria, but absolutely useless in epilepsy.

Since 1902 the writer has given bromides with exclusion of common salt, and has treated about 40 cases of ordinary epilepsy in this way. Several patients, especially such as have come under treatment in youth, have been completely cured. They have taken the bromides for about two years after the last attack, and have since remained well. Others are on the way to recovery. Almost all have been at least much improved.

In the bad cases it was not possible to avoid the two rocks, as the attacks, even if weakened, still persist with doses that set up a disagreeable and disquieting brominism.

ing brominism.

It is of the greatest importance not to neglect the epileptic attacks, they must be treated in a timely and effective manner. If they are taken at once the chances of recovery are great; if, on the other hand, the cases

are neglected, they will eventually become incurable. Experience teaches that.

Absolute deprivation of salt is dangerous; a relative deprivation is sufficient. If disquieting symptoms come on from too large doses of bromides or from complete withholding of salt, a little relaxation of stringency as regards both points will bring things right again. But we should not get frightened and give up the case as hopeless.

Prof. Forel orders the bromides in the following manner:—Potassic brom., sodium brom., ammon. brom., of each 300 to 400 grammes. Well ground and mixed. The patient procures a small pair of apothecary's scales with  $\frac{1}{2}$ , I, and 2 grm. weights, the patient to weigh out every evening the quantity for next day and dissolve it in a litre or more of Dezilit water, one-third to be taken on rising, one-third three-quarters of an hour before the midday meal, and the remainder the same length of time before the evening meal.

# AUSTRIA. Vienna, Jun: 6th, 1909.

THE GROWTH OF CRETINS. JAUREGG gave an account of his results with the thyroid gland on the growth of cretins at the Gesellschaft der Aerzte. He finds the growth in this class increases more rapidly during the first year of treat-ment, and the younger the patient the more effectual the result. In the first year 12 centimetres is the average—i.e., 4.7 in.; after that period the growth is variable, and it is still questionable if we can ever get the patient to the average normal height. There is no doubt the growth can be kept up till puberty, but the rate of increase is so irregular that the normal height is never attained in the cretin. The age of puberty need not deter anyone from the use of thyroid, as he has commenced the treatment at the age of 23 years, with 121 centimetres growth after. Even after the age of 30 years he has had a growth of 4 centimetres. About this age the growth stops quite suddenly, not to move again, while at any other age it stops gradually, or wavers, when it reaches the extreme point. As a rule the cretin moves off under treatment 2 to 3 centimetres the first half-year, but only 1 a centimetre during the second half. This seems to be a fixed law in the treatment; the gland either loses us stimuli or the organism gets more resistant to the effects of the drug, and neutralises the force of growth. Wagner thought the latter was the case, as the drug had no effect on growth where the disease was nonthyrogenic in origin; furthermore, the treatment may be continued for any length of time without injury or any other bad effects on the organism. The explanation seems to be that the drug confines its action to the thyroid gland, and where this is not at fault the results are nil; but if endemic goitre or any of the allied conditions be present, the action is prompt at d effectual. If it does not respond early in cretins even when the thyroid is enlarged, it is useless to persevere in its administration; even in simple functional disturbance of the gland the same rule is valid.

SPONTANEOUS AMPUTATION OF THE APPENDIX.

Friedländer gave the history of a case where the vermitorm process became detached. This was a case of appendicitis which he operated on, but found only a few fragments of the obsolete organ, which were carefully removed, and the wound closed. After this the patient quite recovered, and felt as well as ever. Again the symptoms of appendicitis re-appeared with the more grave signs of perforating peritonitis, for which another operation was performed, and the abdomen freely opened when the appendix was found lying far removed from the original site. It appears that it got quite separated from the bowel in the first attack, and was carried into the abdominal cavity before the first operation, and thus escaped observation. It therefore behoves to operate early, and carefully note any transposition when the entire organ is not present.

Schnitzler recorded a series of analogous cases that had come under his own observation. In several cases with severe attacks of appendicitis with a pause and interval he has frequently found the vermiform entirely separated. On one occasion he found the

appendix in the pouch of Douglas, which by accretions resembled a good-sized pear. This is important to note, as many of our colleagues affirm that this becomes absorbed after being detached, as in the cases cited. This is not always true, and should be carefully examined when any intervals of pause occur.

MORBUS ADDISONII.

Pollak presented a typical case of the disease which had existed for two years. One milligramme of adrenalin did not produce glycosuria, but the lowered function of the chrom. affinity is exalted. On the other hand, if the patient suffers from thyreoidea, I milligramme of adrenalin will produce sugar. It appears there is an additive action or a co-relative function between the adrenalin and the gland.

Porges related other similar cases of morbus Addisonii, where 300 grammes of grape sugar were given, and no glycosuria was produced by the gland when 1 milligramme was injected. There may be some significance in the amount of sugar found in the blood of Addisonii patients. In those which he had examined he found 0.055 and 0.04 per cent. of sugar present, with a blood pressure of 80 millimetres of mercury. In doubtful cases this high percentage of sugar is diagnostic.

## FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### BELFAST.

Belfast Union—Dufferin Children's Hospital.—Last Friday afternoon the new children's infirmary at the Belfast Union was opened by Lady Hermione Blackwood. The building has been designed on the most modern hospital principles, and is a credit to all concerned. It is of red brick, three storeys high, with eight wards to accommodate 200 children. There are large balconies, where the children may enjoy the fresh air in good weather, and both balconies and windows are carefully guarded to prevent accidents. Arrangements have been made by which the wards can be isolated from each other, each ward having its own lavatory accommodation, etc., complete. Lady Hermione Blackwood was welcomed by the chairman of the Board of Guardians, Dr. J. S. Bryars, and at the conclusion of the opening ceremony a vote of thanks was moved by Sir John Byers, M.D.

FEVER TRAINING FOR NURSES.—Up till now the

rever training for Nurses.—Up till now the nurses in the Fever Hospital at Purdysburn have been drawn from the Belfast Union, but a move is on foot to throw open the door to nurses from other hospitals. Applications have been received from the Royal Victoria and the Mater Infirmorum Hospitals, asking that their nurses may have the benefit of training in fever cases, and a special sub-committee of the Public Health Committee has been appointed to confer with the Medical Officer, Dr. Gardner Robb, and draft a scheme.

Sanitary Conditions of Irish Factories.—Considerable interest has been roused by the severe criticisms of Irish factories, chiefly in the North, contained in the anunal report of the Chief Inspector of Factories and Workshops for 1908, just issued. Miss Martindale, the very active and efficient lady inspector, whose services medical men value highly, discloses a very bad state of affairs in many factories. The sanitary accommodation for women and girls is often shocking, and dangerous to health. Two large factories were found in which there was not even a "make-believe" method of warming in winter, even though the factory had been built fairly recently in one case. In March the inspector found the temperature of the rooms in one factory varied from 45° to 54°, and samples of air taken showed as much as 32.8 parts of CO2 per 10,000. In one room with 56 women, the Medical Inspector, Dr. Legge, found over 50 per cent. suffering from anæmia, and as the cases of anæmia were chiefly among those who had worked longest in the factory, the cause was fairly obvious. The inspector took into Court the death certificates of four girls who had been strong, healthy girls previous to working in the factory, with good family history, yet after a few years' work all four had died of phthisis. The

case ended in a conviction, with a penalty of £1 and £5 costs—a most important verdict from the point of view of those interested in the prevention of tuberculosis in Ireland. Miss Martindale is very severe in her strictures on the employment of children, and rightly so. Fancy such a case as one she reports, a child who had practically never attended school owing to delicate health, and yet a week after she was 14 she was sent to a factory where she had to stand the entire day at work. Public opinion in these matters, she says, is in Ireland far behind that in England. She prosecuted a firm on behalf of five little girls who had been employed full time since they were 9 or 10 years old. "It is impossible for me to describe the antagonism aroused in the whole district by this prosecution. Everyone was against me, and the case was dismissed on a small technical point." In concluding her report she adds:—"I have no hesitation in saying that until public opinion is roused the children of the Irish industrial classes will remain weakly and undersized, the high death-rate will continue, and the children will grow up as illiterate as their innate brightness and cleverness will allow."

QUEEN'S UNIVERSITY, BELFAST.—Deep sympathy is felt with the popular Professor of Anatomy, Dr. Symington, at the death of his wife in Edinburgh, where she had gone on a short visit to her relations. The funeral was attended, on behalf of the College staff, by Professors Morton, Gregg Wilson, T. Milroy, and Dr. John Milroy.

and Dr. John Milroy.

Dr. P. T. Crymble has been elected the first holder of the Mackay Wilson Travelling Medical Scholarship, valued at £100 per annum, and has gone to Vienna to carry on his studies there.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

THE NAUHEIM TREATMENT OF DISEASES OF THE HEART AND CIRCULATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the gratifying review of my little book, which appeared in THE MEDICAL PRESS of May 26th, you adversely criticise the last chapter in the following words:

"We must confess that the last chapter, which contains the records of cases successfully treated, does not seem to us to favour the author's contention, for some of the diagrams which illustrate the reduction of the cardiac dulness appear to show that the heart's dimensions after treatment are much smaller than normal. Yet cardiac atrophy, if it could be induced, would scarcely be beneficial. Again, in Case No. 4, that of a patient said to be the subject of aortic stenosis and mitral regurgitation, we should have thought that the presence of the apex beat within the nipple line after treatment, and the pulse tracing given, which shows a sharp apex and a distinct dicrotic notch, would of themselves refute the diagnosis."

I am sure you will allow me a little of your valuable space to answer this criticism.

Firstly, all medical men are aware that the expression "normal cardiac dulness" really means "usual cardiac dulness," and that it is not uncommon to meet with cases of healthy people in which the cardiac dulness is smaller than "normal," although no emphysema of the lungs, or other pathological condition, is present. The shape of the chest, in my opinion, has a very definite bearing on the "normal" cardiac dulness of any one case.

Secondly, several of the cases in Chapter IV. are

Secondly, several of the cases in Chapter IV. are those of women, and in three of these the breasts were large and flabby, and the position of the nipple was by no means an exact anatomical position, but the mid-sternal line and the nipple are the only points that can be satisfactorily indicated in a tracing.

Thirdly, Case No. IV. was that of a woman with large breasts, and the nipple in this case did not indicate a definite anatomical position, and the heart was decidedly hypertrophied. I gave this patient the treatment 15 years ago, and I have just heard from her

medical attendant. He says :-- "She died four or five years ago from hemiplegia, and the cardiac condition was as you have stated."

The intention of the diagrams of cardiac dulness is to illustrate the comparative sizes of the heart before and after treatment, and I contend that they do illustrate this as accurately as any diagrams of a percussed cardiac dulness could do.

As I pointed out in Chapter I., the decrease in cardiac dulness in a case of cardiac dilatation is only

one sign of an improved condition, the general improvement in the health of the patient being a most important indication of a better and more normal state of the heart and circulation, but the improvement in the health of a patient cannot be shown diagrammatically, and the area of cardiac dulness can. It is for this reason that I use these diagrams, and not because I regard them as absolutely accurate anatomical drawings.

Should a further edition of my book be published,

I will not omit to point out the above facts.

In conclusion, I would thank you for your criticism, which has shown me a defect in my book, and has drawn my attention to the fact that the absence of an explanation of the diagrams in the last chapter justifies your criticism.

I am, Sir, yours truly,
LESLIE THORNE THORNE.

53 Queen Anne Street, W., May 29th, 1909.

#### LOCAL GOVERNMENT AND NATIONAL WELFARE

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—The Times of May 20th publishes one of its usual able articles on the supplement to the Annual Report of the Local Government Board. There is very little new to be said upon the question of the scandalous maladministration of sanitary laws which prevails so widely in many districts, but the *Times* repeats its criticism in the usual incisive fashion, without, however, suggesting any remedy for the abuses it exposes The Times finds its chief text in that portion of the report which deals with a number of "urban" districts in the West Riding of Yorkshire. The majority of these so-called urban districts are mainly rural in character; they acquired their urban status under the Local Government Act of 1858, the object being to evade the payment of the county high-way rates. The *Times* points out that, as one result, the roads are very badly kept, but, what is more important, it shows that the salaries paid to Medical Officers of Health are grossly inadequate, and that in most of the districts the sanitary inspector devotes only a fraction of his time to his work, usually combining other occupations with his sanitary appointment, and being in many instances merely a foreman 10ad-mender or a tax-collector. The Medical Officer is under the daily temptation, or necessity, to sub-ordinate the sanitary interests of his district to the maintenance of good relations with his masters, the Authority. It is as much as his place is worth to suggest any action likely to be displeasing to them; they can dismiss him virtually at their caprice; they can dock his paltry stipend; they can refuse to raise it, or give him a retiring allowance on completion of long and faithful services. In a letter which you did me the honour to print a few weeks ago, I pointed out that our attempts at democratic government have so far turned out a failure, and I cited the recent utterarces of Mr. John Burns in advocacy of a return to bureaucratic methods. The only cure for existing evils lies in the election to the authorities of superior men; but superior men won't come forward in face of the apathy displayed by all the classes upon whom the duty of citizenship should be most obligatory. The petty troubles of the underpaid medical officer are, however, as nothing compared with the injury to the State which the present condition of things involves. Within the last few days Dr. Karl Pearson has demonstrated the fact that if our birth-rate continues to decline at its present rate, we shall, in about twelve years, be in the same position as France, with no surplus population. This will mark a final stage in the decadence of the British Empire. Its existence can be prolonged only if our people are physically, mentally, and morally superior to our mighty neighbours in Europe and Asia. It was lately pointed out by one of your correspondents that Germany nas twenty millions more at home than we count in these islands. If by neglect of the teachings of science we allow ourselves to remain as a mass on a lower level of civilisation, there can be no doubt that in time the dominion of the world will fall to the nations with exuberant and virile populations, unspoilt by egoistical vices which are causing the destruction of some of the erstwhile leading peoples of the Western world. The social problem, in the widest sense of the word, is the vital problem. Are our statesmen giving it the attention it so urgently calls for? I, for one, think they are not.

M. O. H.

May 29th, 1909.

#### MEDICAL MISSIONS.

To the Editor of The MEDICAL PRESS AND CIRCULAR SIR,—I rejoice exceedingly at the words spoken at the commemoration day of the Livingstone College as reported in your last issue. When, in 1879, I was impressed by the wretched state of the women and children in "Greater Britain," i.e., India, Ceylon, Africa Burna at besides in those Factors and Africa, Burma, etc., besides in those Eastern parts, not British, where I had been; and when I came to know that often missionaries—men and women—went as messengers of Christianity as regards the soul, but medically ignorant as regards the body-their own as well as those to whom they went—and unable to minister to it, my spirit was stirred within me, and I started the Zenana Medical Mission College. The successes of those women who were trained, and have gone out, as missionaries, amply compensated for the opprobrium heaped on us at the time, and for the time, labour and means bestowed upon the work, and for the discouragements offered by those to whom we looked for encouragement. I wish your pages permitted me to tell of some of the successes of our pupils. and the commendation bestowed upon their while in training, and upon their labours when abroad. "Valuable lives might have been saved if the persons had had the advantage of modern training," said the Master of Trinity, Cambridge University, my cle friend and former fellow student in Dublin. Your report further states: - Prof. Alex. Macalister said: "Doubts had been expressed as to the wisdom of the training given; he thought that these doubts had long since been laid aside, and as an old medical teacher he had complete confidence in the course of training From his experience in many parts of the world especially in Syria and China, he believed that it was a necessity for a missionary to be able to render simple medical aid to the natives, and, in the absence of qualified medical aid, it was most important that ordinary missionaries should have elementary medical training, as is given at Livingstone College. He hoped that before long some such training would be regarded as an absolute necessity for every missionary." I am glad of the success of the Livingstone College for Men, and in the continued successful work amongst women and children of the Zenana Medical Mission College and Hospital.

I am, Sir, yours truly,
G. DE G. GRIFFITH.

London, June 4th, 1909.

#### OBITUARY.

GEORGE HENRY HAMES, F.R.C.S.

WE regret to announce that the death has taken place at Park Lane of Mr. G. H. Hames, who practised in

Mayfair for the past twenty years.

Mr. Hames was medically educated at St. Bartholomew's Hospital and at the Rotunda Hospital, Dublin At St. Bartholomew's Medical School he won both the Kirke Scholarship and gold medal and the Brackan-bury Medical Scholarship in 1875. He was also 2 Foster prizeman. At the hospital he had been both

House Surgeon and House Physician, and had held resident appointments at the Cheyne Hospital for Children and at the Western General Dispensary. Hames qualified as a Licentiate of the Royal College of Physicians in 1876, and as a Fellow of the Royal College of Surgeons in 1878, where he had previously been Prosector. For some years he was the Honorary Secretary of the London Abernethian Society.

#### MILITARY & NAVAL MEDICAL NOTES.

NAVAL medical officers will regretfully hear of the sudden death of Mr. H. W. Temple, I.S.O., who was head of the clerical staff of the Medical Department of the Admiralty. He had almost completed forty years' service, and was to have retired shortly. The Naval and Military Record says he was well known to all naval medical officers, by whom he was held in much respect.

LT.-COL. W. B. BANNERMAN, M.D., B.Sc., I.M.S., has been granted the degree of Doctor of Science in the Department of Public Health, Edinburgh University. The subject of his thesis was "The Action of the Bacillus Pestis on Certain Carbo-Hydrates and Allied Bodies in Liquid Media for the Manufacture of Anti-Plague Vaccine." The officer above-named is the Director of the Bombay Bacteriological Laboratory and Consulting Bacteriologist to the Grant Medical College.

THE Naval and Military Record says that a vacancy on the Surgeon-General's list of the Army Medical Service will occur shortly, when Surgeon-General W. L. Gubbins, C.B., M.V.O., M.B., retires under the age rules. This announcement may be correct, but it is generally reported that this officer's service is to be extended so as to enable him to succeed to the Director-Generalship of the A.M.S., when the present occupant vacates at the end of the present year, or early in March, 1910. The report which is in circulation is given with a sort of "cocksureness" which savours of great probability.

IF we desire to know the unfortunate disappointments and uncertainties of employment, or conditions of employment, in our public services, we cannot do better than study a question and its answer in the House of Commons on "The Egyptian Sanitary Service," Sir E. Grey's answer to Mr. Ramsav MacDonald, M.P. for Leicester, is of the usual shuffling nature. It is difficult to form an opinion of the rights and wrongs of the individuals figuring in the report of the Times, but a very clear warning may be given to those about to enter public services to make sure of their positions, if that is possible, in any public service.

THE DUKE OF YORK'S Royal Military School at Chelsea will be moved to Dover during this year. The history of the move is simply this: A committee of medical experts some time ago pronounced the buildings now occupied as insanitary and unfit for longer occupation as a school. Any alterations to bring it up to date would have cost a large sum. Much opposition to the removal was shown in the public Press, no doubt attributable to the local interests of shop-keepers being affected, and also to the antiquated and highly conservative views of out-of-date people, military and civil. There can be no doubt that in a moral and material point of view the change to Dover is correct, and this, no doubt, will be proved hereafter by greater health and energy among the young lads, chiefly soldiers' sons, who are in the school.

It has been decided that medical officers gazetted to the Territorial R.A.M.C. shall wear R.A.M.C. uniform, but with silver lace and ornaments, unless appointed to units which have permission to wear gold lace. Regimental medical officers who served with Yeomanry and Volunteer Corps, and who have

not joined the R.A.M.C., may, if still serving with their old or reconstituted units, continue to wear regi-mental uniforms with R.A.M.C. belts. Veterinary officers gazetted to the Territorial unattached list will officers gazetted to the Territorial unattached list will wear Service dress of universal pattern. They may also wear Army Veterinary Department full dress uniform, but with silver lace and ornaments. Those having uniform of their former Yeomanry or Volunteer Corps may wear it in addition to Service dress until the end of 1910.

THE following information, given by the Army Service Corps Journal, will be interesting to military and naval medical officers:—"During the late manœuvres in Egypt, at the base of each force-Helouan and Khanka-field bakeries were erected, and all the bread for the troops was baked at these places. The cattle were driven on the hoof and prepared for consumption at each camp. Though the railway was available at practically every camp, this mode of conveyance was entirely discarded, it being assumed that the railway was non-existent. Camels were used for all transport services. A very interesting experiment was made by sending a quantity of frozen meat by camel, a distance of 88 miles. On its journey the temperature attained a height of 88°. The meat was inspected and issued on arrival, and was found to-be perfectly fresh and palatable."

#### SPECIAL ARTICLES.

#### THE NATIONAL UNIVERSITY OF IRELAND.

THE Dublin Commissioners appointed under the Irish Universities Act, 1908, to make Statutes for the general government of the University which has since been incorporated under the name of the National University of Ireland, have made the Statutes for the general government of the University and its constituent Colleges.

The degrees in the Faculty of Medicine will be:—

Bachelor of Medicine (M.B.), Bachelor of Surgery (B.Ch.), Bachelor of Obstetrics (B.A.O.), Bachelor (B.Ch.), Bachelor of Obstetrics (B.A.O.), Bachelor of Science, Public Health (B.Sc., Public Health), Master of Surgery (M.Ch.), Master of Obstetrics (M.A.O.), Doctor of Medicine (M.D.), Doctor of Science, Public Health (D.Sc., Public Health), Bachelor of Dental Surgery (B.D.S.), Master of Dental Surgery (M.D.S.).

Dental Surgery (M.D.S.).

In University College, Dublin, in the Faculty of Medicine there will be the following Professorships and Lectureships at the appended stipends:—\*The Professorship of Chemistry, £750; \*the Professorship of Experimental Physics, £800; \*the Professorship of Zoology, £600; \*the Professorship of Anatomy, £800; \*the Professorship of Pathology and Histology, £700; \*the Professorship of Hygiene and Medical Jurisprudence, £250; the Professorship of Materia Medica and Therapeutics, £200; the Professorship of Medicine, £250; the Professorship of ### And The Professorship of Medicine, £250; the Professorship of Midwifery and Gynæcology, £200; the Professorship of Surgery, £300; \*the Lectureship in Physics, £300; \*the Lectureship in Botany, £350; the Lectureship in Ophthalmology, £50; the Lectureship in Dental Mechanics, £50; the Lectureship in Dental Surgery, £50; the Lectureship in Special Pathology, £250.

Pathology, £250.

In University College, Cork, the Professorships and Lectureships will be: — \*The Professorship of Chemistry, £600; \*the Professorship of Scology, £550; \*the Professorship of Anatomy, £600; the Professorship of Medicine, £200; the Professorship of Obstetrics and Gynæcology, £200; \*the Professorship of Obstetrics and Gynæcology, £200; \*the Professorship of Physiology, £600; the Professorship of Surgery, £250; the Professorship of Therapeutics, £100; the Lectureship on Hygiene, £50; the Lectureship on Medical Jurisprudence, £50; the Lectureship on Mental Diseases, £50; the Lectureship on Ophthalmology, £50. mology, £50.
In University College, Galway, the Professorships

and Lectureships will be:—\*The Professorship of Physics, £350; \*the Professorship of Chemistry, £350; \*the Professorship of Natural History, Geology and Mineralogy, £350; \*the Professorship of Anatomy and Physiology, £350; the Professorship of Medicine, £150; the Professorship of Surgery, £150; the Professorship of Obstetrics and Gynæcology, £150; the Professorships of Materia Medica and Pharmacy, £150; the two Lectureships on Medical Jurisprudence and the two Lectureships on Medical Jurisprudence and Hygiene, £40 each; the Lectureship on Fever cases,

£20. [Professorships and Lectureships in the above list to which an asterisk is prefixed shall be considered to be, and shall be, Full Time Professorships and Lecture-

#### MEDICAL NEWS IN BRIEF.

#### Royal College of Surgeons in Ireland-Annual Election.

THE annual meeting of the Fellows was held on Saturday last, June 5th, the President, Mr. J. Lentaigne, in the chair. A favourable report was submitted. During the year 19 candidates, having passed the examination, were admitted Fellows; 48 obtained the Licence, 27 the Diploma in Public Health; 16 the Licence in Dental Surgery, and 70 passed the entrance examination. The obituary list showed that 8 Fellows and 28 Licentiates died during the year. There are at present living 484 Fellows, 2,910 Licentiates, 303 Diplomates in Public Health, and 538 Licentiates in Dental Surgery.

At a meeting of the Fellows held on Monday, June 7th, the following were elected for the ensuing

President.—John Lentaigne, F.R.C.S. Vice-President.—Robert H. Woods, F.R.C.S. Secretary of the College.—Sir Charles A. Cameron,

C.B., F.R.C.S.

C.B., F.R.C.S.

Council.—Sir Henry R. Swanzy, F.R.C.S.; William Stoker, F.R.C.S.; Sir Charles Alexander Cameron, C.B., F.R.C.S.; John B. Story, F.R.C.S.; Sir Charles B. Ball, F.R.C.S.; Sir Thomas Myles, F.R.C.S.; Sir Arthur Chance, F.R.C.S.; Richard D. Purefoy, F.R.C.S.; Sir Lambert H. Ormsby, F.R.C.S.; Henry G. Sherlock, F.R.C.S.; R. Bolton M'Causland, F.R.C.S.; R. Lane-Joynt, F.R.C.S.; William Taylor, F.R.C.S.; Edward H. Taylor, F.R.C.S.; G. Jameson Johnston, F.R.C.S.; R. Charles B. Maunsell, F.R.C.S.; William Ireland Wheeler, F.R.C.S.; D. Edgar Flinn, F.R.C.S.; Thomas E. Gordon, F.R.C.S.

#### A Medical Visit to Harrogate.

DR. DR MOUILLOT, of Harrogate, as President of the Irish Medical Schools' and Graduates' Association, invited a number of prominent members to pay a week-end visit to this favourite health resort, the Mayor, Alderman Balmforth, and many members of the Harrogate Medical Society, joining heartily in the reception and entertainment of the visitors. On Saturday Dr. Sibley arranged and conducted an excellent concert on their behalf, after which Dr. and Mrs de Mouillot held a reception in the Kursaal grounds, where tea was served. In the evening a banquet was held at the Majestic Hotel, the President of the Association occupying the chair. He was supported by the Mayor and Mayoress, and, among others, by the following members of the profession and their ladies:—Drs. J. G. Black, Shepherd Boyd, Hind, and C. Gibson, J.P., Harrogate; Dr. Crawford Watson (President of the Harrogate Medical Society), Dr. E. Solly (President of the Balneological Society), Dr. H. Macnaughton-Jones (London, Vice-President), Dr. Macan (Cheam, Chairman of the Council), Dr. Michael J. Bulger (London, Hon. Treasurer), Dr. Thos. H. Crampton and Dr. Geo. Wm. Dawson (London, Hon. Secretaries), Dr. P. Abraham and Dr. Fegan (London), Dr. Peters, Dr. Lever, Dr. Nimmo de Mouillot held a reception in the Kursaal grounds, Fegan (London), Dr. Peters, Dr. Lever, Dr. Nimmo Watson, Dr. Bertram Watson, Dr. A. W. Hinsley Walker, Dr. J. B. Story and Dr. Delahoyde (Dublin), Dr. Fitzgerald, Dr. Campbell Boyd, Dr. D. Wilson, Dr. Franklin, Dr. H. Thompson, Dr. Wilkinson, Dr. Robinson, Dr. Beardsley, Dr. McKee, Dr. Mantle,

Dr. Wills, Dr. Pringle, Dr Ross, Dr. Brown, Dr. Morris, Dr. David Browne, Dr. Bain, Dr. Laura Veale, Dr. and Mrs. Edgecombe, Dr. Atkinson, Dr. O'Brien, Dr. Rutherford, Dr. Liddell, Dr. Pronger, Dr. Jacobs, Dr. Thompson, Dr. Garrad, Dr. Campbell Ward, Mr. J. Turner Taylor (Town Clerk). Considerable anthusian was availed in the creather as to interest the contraction of the able enthusiasm was evoked in the speeches as to the remarkable resources and beauties of Harrogate as a health resort, and as a bathing centre second to none in Europe. The toast of the Harrogate Medical Society was proposed by Dr. Macnaughton-Jones and responded to by Dr. Crawford Watson, and that of the President by Dr. Solly. On Sunday the visitors were taken in automobiles to various places of in-terest, and altogether the visit proved of exceptional interest.

#### Death from Cocaine.

AT Newcastle Infirmary on June 2nd, the City Coroner resumed an inquest on J. T. Lauderdale, 2ct. 19, draper's assistant When the inquest was opened it was stated that Lauderdale went to the Infirmary to be operated on for a growth in his right nostril. Otherwise he was in good general health.

Mr. Walker, House Surgeon, said the operation was to have been performed at noon on Saturday. At 11.30 Lauderdale's nostrils were packed with lint soaked in cocaine hydrochloride to act as a local About ten minutes afterwards the deanæsthetic. ceased walked into the operating room and the doctor asked him how he felt. He replied that he was all asked him how he felt. He replied that he was all right. Witness left the room for a few minutes. When he returned, the deceased's breathing was laboured, and he had four convulsive fits and died. Witness thought death was due to the cocaine becoming absorbed in the mucous membrane of the nose which had the effect of producing convulsions and respiratory troubles.

Dr. George Hall, pathologist to the Infirmary, who made a post-mortem examination, said all the signs pointed to death through asphyxia, probably caused

by the action of the cocaine.

Answering the Coroner, Dr. Hall said he did not think the delay of twenty minutes between the administration of the cocaine and the operation was an unreasonable time.

Nurse Pattinson said it had been the practice for the sister and staff nurses to give local anæsthetics in minor cases. She had never previously seen a case of collapse.

The jury returned a verdict in accordance with the

medical evidence.

#### Lord Lonsdale and Vivisection.

MISS LIND-AF-HAGEBY, hon. general secretary to the International Anti-Vivisection and Animal Protection Congress, writes in reply to Lord Lonsdale's statements as to his attitude towards vivisection, quoted in The Times of May 26th :-

"Lord Lonsdale has held the position of hon. treasurer to the congress for five months, and his present action comes as a complete surprise to the committee. . . . In inviting Lord Lonsdale to become the hon, treasurer of the congress the organising committee bore in mind that he has for several years been a vice-president of the Incorporated Parliamentary Association for the Abolition of Vivisection, and that he recently gave £100 to that association, for the activities of which he has expressed sympathy. On November 20th last he expressed his pleasure at becoming the hon. treasurer of the Anti-Vivisection and Animal Protection Congress, and later on promised to subscribe £50 to the special congress promised to subscribe £50 to the special congress fund. On May 20th Lord Lonsdale signed a public letter of appeal, completely identifying himself with anti-vivisection, and referring to the great moral, social, and scientific importance of the issue for which we fight.' . . . The officials and committee of the congress can accept no responsibility for Lord Lonsdale's incomprehensible changes of mind, or for the presence of his signature upon the letter of appeal for assistance to a cause which, as it turns out, had in him so weak a champion."

The public letter of appeal referred to by Miss Lind-af-Hageby as having been signed by Lord Lonsdale contains the following statement:—"The width of our scheme and its inclusion of other forms of animal protection will strengthen rather than weaken the anti-vivisection work of the congress and will constitute a practical protest against the efforts of vivisectors to exclude scientific cruelty to animals from the ban placed upon ordinary cruelty."—Times.

#### The New Milk Bill.

THE important Milk and Dairies Bill [Bill 216] introduced by the President of the Local Government Board and read a first time in the House of Commons on the 25th ult., has now been printed. It has as its main objects (1) the more effective registration of dairies and dairymen; (2) the inspection of dairies and the examination of cows therein; (3) the prohiand the examination of cows merein; (3) the promi-bition of the supply of milk from a dairy where such a supply has caused or would be likely to cause infectious diseases, including tuberculous; (4) the prevention of the sale of tuberculous milk; (5) the regulation of the importation of milk so as to prevent danger to public health arising therefrom; (6) the issue of regulations for securing the supply of pure and wholesome milk; (7) the establishment by local authorities in populous places of milk depôts for the sale of milk specially prepared for infants.

#### Medical Motorists and the Budget.

MR. C. B. LOCKWOOD, F.R.C.S., of St. Bartholomew's Hospital, occupied the chair at a special meeting of the Motor Union Committee of Medical Motorists. at the offices of the Union a few days ago to consider the Budget proposals of the Chancellor of the Exchequer in so far as they affect members of the medical profession using motor-cars. There was a representative attendance of medical men, members having travelled from the North and West of England in order to be present at the meeting. The committee resolved that the motor-car has now become an absolute necessity to a medical practitioner who is therefore en sity to a medical practitioner, who is, therefore, entitled to make a special claim for abatement. It was resolved to approach the Chancellor of the Exchequer with a view to securing a rebate of 1½d. per gallon on petrol used by medical men. A letter was read from Mr. W. Joynson Hicks, M.P. (chairman of the Motor Union), stating that the Chancellor had agreed to receive a deputation on the matter.

#### State Grant in Aid of Scientific Investigations.

In connection with the annual grant voted by Parliament in aid of scientific investigations concern-

rariament in aid of scientific investigations concerning the causes and processes of disease, Mr. Burns, the President of the Local Government Board, has authorised the following special researches:—

1. A continuation of the investigation into protracted and recurrent infection in enteric fever, by Dr. Theodore Thomson, Medical Inspector of the Board, in conjunction with Dr. Hedingham, of the Lister Institute.

2. A continuation of the investigation into pro-tracted and recurrent infection in diphtheria, by Dr.

Theodore Thomson and Dr. C. J. Thomas.

3. A continuation of the investigation into flies as carriers of infection by Dr. Monckton Copeman, Medical Inspector of the Board, and by Professor Nuttall, of Cambridge.

A continuation of Dr. Andrewse, investigation on

4. A continuation of Dr. Andrewes' investigation on the presence of sewage bacteria in sewer air, with a view to ascertaining their number and the distance they can be carried by air currents. Also a continuation of Dr. Andrewes' investigation into the part played by changes in bone marrow in the defensive mechanism of the hody against infection

mechanism of the body against infection.

5. A continuation of Dr. Savage's investigation on the bacterial measurement of milk pollution, and on the presence of the Gaertner group of bacilli in prepared measurement of milk pollution.

6. An investigation into the chemical and physical changes undergone by milk as the result of infection by bacteria, and into the relation of the pancreas to epidemic diarrhea, by Dr. Schölberg and Mr. Wallis, of University College, Cardiff. 7. An investigation of the records of charitable lying-in hospitals as to the nutrition of the mother and other factors influencing the vitality of infants and their progress in the first fourteen days of life, by Dr. Darwall Smith, Physician to the British Lyingin Hospital.

8. An investigation into the occurrence and importance, in relation to treatment, of mixed infections in pulmonary tuberculosis, by Dr. Inman, pathologist to the Brompton Hospital for Consumption.

9. An investigation on the relative importance of certain types of body-cells in defence against the tubercle-bacillus, and the effect of tuberculin and other remedial agents on their activities, by Dr. J. Hiller, Pathologist to the General Hospital, Birmingham.

#### PASS LISTS.

University of London.

THE following candidates passed the M.B., B.S.

xamination during May:

Honours Division.—Albert Harold Godwin Burton Honours Division.—Albert Harold Godwin Burton (c), Guy's Hosp.; Reginald Robert Elworthy (a), Westminster Hosp.; Augustin Pownall Fry (d), St Bartholomew's Hosp.; Manchersha D. D. Gilder (d), University College Hosp.; Cecil Augustus Joll, B.Sc. (a, b, c, d, University Medal), Univ. Coll., Bristol; Dan Arthur Powell (a), Charing Cross Hosp. (a) Distinguished in Medicine. (b) Distinguished in Pathology. (c) Distinguished in Forensic Medicine and Hygiene. (d) Distinguished in Surgery.

Ordinary Pass.—Leonard T. Baker, Guy's Hosp.;

Hygiene. (a) Distinguished in Surgery
Ordinary Pass.—Leonard T. Baker, Guy's Hosp.;
Stanley J. Beale, London Hosp.; Trevor L. Bomford,
St. Bartholomew's Hosp.; Robert H Bott, St. Bartholomew's Hosp.; Karl Bremer, St. Bartholomew's
Hosp.; Charles H. Broomhead, Victoria Univ., Manchester;
Elsie M. Chubb, Lond. (R.F.H.) Sch. of Med. for
Women; Lawrence Croft, Guy's Hosp.; Sydney J.
Darke, Guy's Hosp.; Harry C. R. Darling, University
Coll. Hosp.; Trevor B. Davies, University Coll.
Hosp.; Newton C. Davis, St. Bartholomew's Hosp.;
Gopal V. Deslmukh, London Hosp.; Irene C. D.
Eaton, Lond. (R.F.H.) Sch. of Med. for Women;
Albert E. Evans, University Coll. Hosp.; Thomas
Evans, Guy's Hosp.; Claude H. S. Franknau, St.
George's Hosp.; Wm. Lionel E. Fretz, University
Coll. Hosp.; Janet M. Fishe, Lond. (R.F.H.) Sch. of
Med. for Women; Harold S. Furness, University Coll.
Hosp.; Colin J. Galbraith, Kirg's Coll. Hosp.; Horace
Gooch, London Hosp.; Alexander E. Gow, St. Bartholomew's Hosp.; Frederick W. Hogarth, Guy's
Hosp.; Edward R. Holborow, University Coll.,
Bristol; Maurice J. Holgate, St. Bartholomew's Hosp.;
Alan W. Holthusen, St. Bartholomew's Hosp.; Harold
F. L. Hugo. Charing Cross Hosp.: Matilda Hunt. Ordinary Pass.—Leonard T. Baker, Guy's Hosp.; Alan W. Holthusen, St. Bartholomew's Hosp.; Harold Alan W. Holthusen, St. Bartholomew's Hosp.; Harold F. L. Hugo, Charing Cross Hosp.; Matilda Hunt, Lond. (R.F.H.) Sch. of Med. for Women; John L. Johnston, Guy's Hosp.; Evan J. G. Jones, University Coll. Hosp.; Roger P. Jones, University Coll. Hosp.; Simmer D. Judson, Victoria Univ., Manchester; Herbert C. Lucey, Guy's Hosp.; Graham R. Lynn, St. Bartholomew's Hosp.; John C. Lyth, Univ. of Leeds; Howard E. H. Mitchell, Guy's Hosp.; M. Herschel E. R. Montesole, St. Thomas's Hosp.; Henry L. Morgan, London Hosp.; Wm. P. H. Munden, Guy's Hosp.; Walter H. Palmer, London Hosp.; Owen B. Parry, St. Mary's Hosp.; Jean R. Perdrau, Guy's Hosp.; Ellen M. Pickard. Lond. (R.F.H.) Sch. of Med. for Women; Laura G. Powell, Lond. (R.F.H.) Med. for Women; Laura G. Powell, Lond. (R.F.H.) Sch. of Med. for Women; Thomas E. Pryce, University Coll. Hosp.; William P. Purdom, Guy's Hosp.; Roger A. Rankine, Guy's Hosp.; Hubert A. H. Robson, St. Thomas's Hosp.; Hubert A. H. Robson, St. Thomas's Hosp.; John E. Scudamore, London Hosp.; Florence Stacey, Lond. (R.F.H.) Sch. of Med. for Women; Marion Stocks, Victoria Univ., Manchester; St. John Alex. M. Tolhurst, Guy's Hosp.; Sydney A. Tucker, St. Bartholomew's Hosp.; James Owen D. Wade, Charing Cross Hosp.; Herbert G. Willis, St. Mary's Hosp.; Charles A. Wood, Guy's Hosp.

#### NOTICES TO CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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DR. G. D G.—We have forwarded your letter to the Chairman

DR. G. D G.-We have forwarded your letter to the Chairman

OR. G. D. G.—We have lorwarded your letter to the continuous of Committee.

QUARRENS.—Hydrocystoms is a harmless retention cyst of the sweat-ducts. It occurs chiefly in the face of women who perspire freely (said to be especially common in laundresses). The cysts are discrete, of a size from that of a pin-head to a pea. Puncture, and use a dusting powder.

and use a dusting powder.

DR. DABBS ON THE BUDGET.

Our confrère, Dr. G. H. R. Dabbs, in the June issue of his journal, is a little cynical about the Budget and its author. He says he might write a great deal about the subject, but refrains from doing so, as the matter has already been summed up so wittily by another with the simple quotation from an old nursery rhyme: "Taffy was a Welshman, Taffy was a —" Rus IN URBE.—The law of libel is in a most unsatisfactory condition, but we cannot gather from the letters submitted to us that you have written anything actionable. As you are a member of the Medical Defence Union, you had better write at once to Dr. A. G. Bateman for advice.

FREE MEDICAL PUPILAGE FOR A LADY.

once to Dr. A. G. Bateman for advice.

FREE MEDICAL PUPILAGE FOR A LADY.

A CORRESPONDENT, who is the hon. secretary to a well known
Zenana Medical Mission College and Hospital, in London, writes us
that friends of the institution have placed sufficient funds in his hands
to enable the College to take a free pupil for two years' training, so
that the lady selected would have none but her own personal expenses
to meet. Should any of our readers have a daughter or lady friend
anxious to undertake medical mission work, and will communicate an
once to the Editor of this journal, at the London office, he will put the
matter in the right channel.

Acquirect (Britist)—If you get a coloured glass oun (sold for

Aguracus (Bristol).—If you get a coloured glass cup (sold for the purpose), and place in front of the lens during exposure, you can equalise the colour values, and so get photographs of coloured skin conditions capable of reproduction.

#### Meetings of the Societies, Tectures, &c.

WEDNESDAY, JUNE 9TH.

UNITED SERVICES MEDICAL SOCIETY (Royal Army Medical College, Millbank, S.W.).—8.30 p.m.: Captain E. B. Waggett, R.A.M.C. (T.): The Mouth, Nose, Throat, and Ear from the Point of View of Recruiting.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. R. L. Evans: Clinique (Surgical). 5.15 p.m.: Lecture: Mr. F. Jaffray: Appendioitis—Symptoms and Diagnosis.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

TRURSDAY, JUNE 10TH.

ROYAL SOCIETY OF MEDICINE (OBSTETRICAL AND GYNECOLOGICAL SECTION) (20 Hanover Square, W.).—7.45 p.m.: Specimens: Dr. G. E. Purslow: (1) Uterus, with Fibroid Tumour, from a Case in which Cessrian Hysterectomy was performed; (2) Bilateral Ovarian Tumcurs, One of which Obstructed Labour on Two occasions. Dr. W. J. Gow: Cancer Originating Separately in the Uterine Body and in the Cervix. Short Communications: Mr. J. Bland-Sutton: Red Degeneration of a Uterine Fibroid, associated with the Staphylococcus Pyogenes Aureus. Dr. G. Darwall Smith: An Unusual Solid Tumour of the Ovary. Dr. Blair Bell: A Case of Rudimentary Uterus Didelphys, with Ectopia of Each Uterine Body in an Inguinal Hernia Sac; with Some Remarks on the Development of the Female Genital Organs.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINODOM (1) Chandos Street, Cavendish Square, W.).—8 p.m.: Card Specimens will be shown by Mr. F. Fergus, Mr. F. W. Edridge-Green, Mr. A. Lawson, Mr. J. H. Fisher, and others. 8.30 p.m.: Mr W. H. H. Jessop: The Report of the International Committee on the Unification of the Notation of Visual Acuity and of the Meridians of Astigmatism. Mr. P. H. Adams: (1) A Family with Congenital Displacement of Lenses; (2) A Family with Congenital Opacities

of Lenses. Mr. A. H. Griffith and Mr. A. W. Ormond: A Case of Retinal Disease with Massive Exudation and Arterio-venous Communication. Dr. G. Mackay: An Epithelal Filament in the Anterior Chamber, Simulating a Thread Worm.

MEDICAL GRADMATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical). 5.15 p.m. Lecture: Mr. J. Clarks: The Clinical Examination of Spinal Cases.

NORTH-EAST LONDON POST-GRADMATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynscological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Special Demonstration: Dr. T. R. Whipham: Cases of Children's Disease.

FRIDAY, JUNE 11TH.

FRIDAY, JUNE 11TH.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11
Chandos Street, Cavendish Square, W.).—5 p.m.: Special Meeting.
Mr. Nettleship: Some Diseases of the Eye illustrating Heredity.
(Bowman Lecture.)
MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenics
Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique (Ear, Nose, and
Throat).

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray'S Inn Road, W.C.).—3.45 p.m.: Lecture: Mr. C. Nourse: Middle Ear Labyrinth.

#### Appointments.

BALT, A. L., M.R.C.S., L.R.C.P.Lond., First Assistant Medical Officer at the Lambeth Infirmary.

BIDIE, EVAN, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Assistant Medical Officer at Wye House Asylum, Buxton.

BYGOTT, ALBERT HENRY, M.D.LOnd., D.P.H.Birm., Barrister-atlaw, Medical Officer of Health of Barking.

HAILES, C. D. G., M.D.Edin., F.R.C.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Bristol District of the county of Gloucester.

HALL, JOHN BASIL, M.B., B.C.Cantab., F.R.C.S.Edin., one of the Medical Referees under the Workmen's Compensation Act, 1906, for County Court Circuit No. 11, to be attached more particularly to Bradford, Keighley, Otley, and Skipton County Courts.

#### Bacancies.

Mercers' Hospital, Dublin.—Gynsecologist. Applications to the Registrar. (See advt.).

House of Recovery and Fever Hospital.—Junior Assistant Resident Medical Officer. Salary, £50, and board. Applications to the Medical Superintendent. (See advt.)

Lurgan Union.—Female Resident Medical Officer. Salary, £80 per annum, with extras. Immediate applications to James Calvert, Clerk of Union. (See advt.)

Bolingbroke Hospital, Wandsworth Common, S.W.—Resident Medical Officer. Salary, £150 per annum, with board and residence. Applications to the Hon. Sec. of the Medical Committee, Bolingbroke Hospital.

Birmingham General Dispensary.—Resident Surgeons. Salary, £170 per annum (with cab allowance of £30 per annum), and furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.

Walsall and District Hospital.—House Surgeon. Salary, £100 per annum, with board and residence. Applications to Harold Wigg, Co.-Secretary.

Walsall and District Hospital.—Junior House Surgeon. Salary, £30 per annum, with board and residence. Applications to Harold Wigg, Co.-Secretary.

#### Births.

BASHFOED.—On June 4th, at 18 Downshire Hill, Hampstead, London, the wife of H. H. Bashford, M.D., of a daughter.
COOPER.—On June 5th, at Lansdowne, Hampton-on-Thames, the wife of Harold Merriman Cooper, M.B. (London), of a son.
DENYER.—On May 30th, at 26 Albion Street, Hull, Yorks, the wife of Stanley E. Denyer, C.M.G., M.D. Cantab., F.R.C.S. Eng., of a daughter.

Stanley E. Denyer, U.M.G., Salt. Canada, daughter.

KINNZER.—On May 21st, at Royton Hall, Royton, near Oldham, the wife of Forbea Kinnear, M.B., of a daughter.

WALKER.—On May 30th, at Hing-Hwa, South China, the wife of Dr. Donald R. Walker, of a son.

WHITE.—On May 5th, at Spring Grove, Louis Creek, North Thompson Valley, British Columbia, the wife (nee Ethel Palmer Budd) of Malcolm White, M.R.C.S., L.R.C.P., etc., of a son.

of a son.
WILSON.—On June 5th, at 22 Hilgreve Road, London, the wife of
J. Clark Wilson, M.D., M.R.C.P., of a daughter.

#### Marriages.

SHIPMAN—BOUSFIELD.—On June 2nd, at the Parish Church, Grantham, George Alfred Cargill Shipman, M.A., M.B., youngest son of Dr. G. W. Shipman, of Grantham, to Dorothy Louisa Bousfield, only daughter of the late Rev. Stephen Bousfield, M.A., Rector of Shelton, Notts, and Mrs. Bousfield, Grantham.

#### Beaths.

HARRISON.—On June 3rd, at 55 Hanover Gate Mansions, London, Jane, widow of Reginald Harrison, F.R.C.S., in her 70th year.

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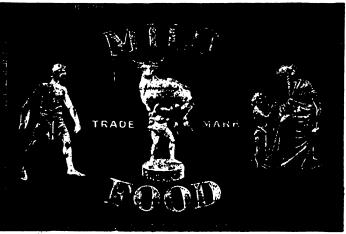
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By augmenting the peristaltic movement of the intestine without producing undue secretion of the liquids. Unlike pills and the usual purgatives, it does not predispose to intestinal sluggishness; and the same dose always produces the same effect—that is to say, never needs increasing.

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# ADRENALIN CHLORIDE SOLUTION 1:1000.

This solution, diluted with 10 to 20 volumes of physiological sodium chloride solution (1 Compressed Tablet Sodium Chloride, P., D. & Co., No. 365, dissolved in 4 fl. ounces of recently-boiled distilled water), may be sprayed into the nostrils or applied on pledgets of cotton-wool to the septum and the accessible portions of the lower and middle turbinates, and also instilled into the eyes.

A writer in the *British Medical Journal*, 4th July, 1903, p. 60, states that relief was obtained by using this solution when the paroxysm threatened.

Supplied in bottles of 1 fluid ounce and 10 c.c., also in ampoules of 0.5 c.c.

#### SOLUTION || ADRENALIN INHALANT.

This 1:1000 solution of Adrenalin Chloride in aromatised neutral oil containing 3 per cent. of Chloretone, secures more prolonged contact with the mucous membrane than does the aqueous solution. The antiseptic and analgesic properties of Chloretone are valuable auxiliaries. When thus exhibited, the action of the Adrenalin is so mild that dilution is not necessary. The Inhalant may be sprayed into the nostril and repeated in four hours if required.

A writer in the Medical and Surgical Monitor for January, 1905, records several cases of chronic hay fever successfully treated with Adrenalin Inhalant.

Supplied in bottles of 1 fluid ounce.

ADRENALIN OINTMENT, a combination of 1 part of Adrenalin Chloride in 1000 parts of a bland oleaginous base, is preferred by some medical men as it prolongs local ischæmia.

Supplied in collapsible tubes with elongated tips to facilitate nasal medication.

Prior to using either of these preparations, crusts of mucus should be removed from the nasal passages by a spray of warm alkaline solution such as may be obtained by diluting ALKATHYMOL (P., D. & Co.) with three volumes of warm wacer, or by dissolving one Compressed Tablet NASAL (P., D. & Co., No. 34) in four ounces of tepid water.

The "GLASEPTIC" NEBULISER is the most suitable appliance for administering Adrenalin Chloride Solution or Adrenalin Inhalant. Being free from metallic fittings danger of contamination is avoided, and having no vulcanite parts it may be readily sterilised by boiling.

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PARKE, DAVIS & Co., London.

270 mg

# Phosphorus Metabolism. Sanatogen Period. After Period. Period.

#### 4-9 day, 440 mg. Phosphorus Retention pro die.

# Sanatogen

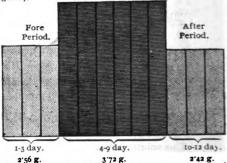
The virtue of Sanatogen is semething more than the sum of the action of its two component parts (Casein + Glycero - phospheric acid). Both these substances are of well-tried value, but in Sanatogen they are so blended and chemically combined as to constitute a new compound with properties exactly adapted to the wants of the human organism, and with quite specific therapeutic qualities.

A contribution to the study of the action of Sanatogen has been made by an English authority who conducted a series of investigations into its metabolism. They were submitted to the International Medical Congress at Lisbon in 1906, and published in the "Archives Internationales de Phar-

macodynamie et de Therapie," Vol. XVI. (See accompanying diagram).

#### Nitrogen Metabolism.

Sanatogen Period.



Nitrogen Retention pro die.

#### The conclusions of the author were as follows:-

 The retention of nitrogen by the system during the taking of Sanatogen is 48% more than on an ordinary diet.

10-12 day.

350 mg.

- (2) The retention of Phosphorus shows an increase of 63% during the administration of Sanatogen.
- (3) Practically the whole of the phosphorus in Sanatogen becomes assimilated.
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Used with the greatest success in Tonsillitis, Stomatitis, Thrush, etc.

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The above illustration shows an Agar Plate, the two halves of which were treated with Normal and Formamint Saliva respectively. Both were then inoculated with a typhoid culture. The right half, containing Normal Saliva, developed a virulent growth of the Colonies, whereas on the left half, containing Formamint Saliva, only scratches of the inoculation Spatula are visible. Such is the protection afforded by Formamint against all infectious diseases which effect their entry through the mouth.

#### An Efficient Prophylactic against Infectious Diseases,

such as Scarlet Fever, Diphtheria, Measles, etc.

"THE PRACTITIONER," December, 1907, vide Article on "An Analysis of 832 Cases of Scarlet Fever":—

"I regard these lozenges or tablets as a good prophylactic also against sore throat. I have never had a sore throat myself since I began to use them, although I periodically suffered before, and I always recommend their use to the nurses in the scarlet fever wards."

Beware of inefficient substitutes, which, not being chemical combinations, like Formamint, cannot act in the same manner. Insist on "Formamint Wulling."

# Formamint

# THE MEDICAL PRESS

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, JUNE 16, 1909.

No. 24.

#### NOTES AND COMMENTS.

Cosmopolitan Quackery.

THE existence of quackery in all nations of the world, whether civilised or otherwise, points to some common defect in the intellectual armour of mankind. Viewed

in the light of common-sense criticism and reduced to its first principles, there is nothing more ridiculous in the fantastic dress and capers of the North American "medicine man" than of the faith-healer of fashionable New York or London, who lays on his hands and prays over an unfortunate victim dying perchance of pneumonia or appendicitis. There is more excuse for the savage, however, inasmuch as he has probably no sounder system of scientific healing available than his own incantations. In London there have been for generations past one or two notorious bone-setting quacks, who have successfully defied the storms of time and amassed fortunes in comfortable security. In Paris their homologue is the famous Jacob the Zouave, who served in the Crimean war, and is a famous trombone player. For at least fifty years he has followed the lucrative calling of a faith-healer. He has been prosecuted again and again for practising medicine illegally, but without the slightest effect. The latest experience of the Courts appears to have placed him finally on a pinnacle of safety whence he may laugh at the enemy. A prosecution was undertaken against him by the Association of Physicians of the Department of the Seine, but the Court decided, as usual, in favour of Jacob. They held that a man who wore a long white gown, and who claimed to be in communication with spiritual agencies whom he could invoke at will, and who shook hands with his patients, could not be regarded as practising medicine. It would be interesting to get a definition from that particular Court of illegal medical practice. Meanwhile, we have our own Jacobs and our own Courts of special leniency towards gentlemen of his kidney.

Physician.

It is is seldom given the whole world The Sultan's to rejoice together over the degradation of a single person, but it is safe to say that every civilised being, not pecuniarily interested in the Court of

Abdul Hamid, has been relieved and delighted by the downfall of that blood-stained potentate. Even the ladies of his harem seem to have taken separation from their lord and master with great philosophy, and let it be hoped they may find such reward as Turkey has to offer for premature divorce. But we can understand that the revolution will not be contemplated with unalloyed satisfaction by Dr. Bier, the ex-Sultan's German physician, who was attached to his employer's Court at the handsome remuneration of £6,000 a year. Indeed, he is already

reported to be about to sue the Sultan's legal successor for damages for breach of contract, and perhaps, in commemoration of the new order of things, he will be awarded a decent solatium. To his professional confrères in this country, however, it will probably be felt that as a member of the profession he has had ample opportunity of providing for a rainy day out of the salary of a Lord Justice, when the highest official posts open to medical men in this country only carry a quarter of his salary, and the medical attendants of Royalty are reputed to be paid in hundreds which bear a very small proportion to Dr. Bier's thousands. At the moment we can only think Dr. Bier rather lucky, in a country like Turkey, to have escaped the revolution with only the loss of his position; if the Young Turks had followed the precedents of previous revolutionaries in their country, he would probably have lost his head also.

Death Certification.

THE medical profession is unanimous about the necessity of revising the present methods of death certifica-Certification: tion; perhaps more unanimous on that than any other subject, and we are glad to see the matter brought forward in

public on every good occasion. Nevertheless, it seems unfortunate that the occurrences at Wolverhampton, much trumpeted in the papers last week, was gravely made the subject of a question in the House of Commons. The incident in question consisted in the fact that a woman suffering from tuberculosis of the lungs and cerebral hæmorrhage died, and the husband applied to the medical attendant in due course for a death certificate, which was duly given. A nurse and some other women subsequently suspected that life was not extinct, and, placing a mirror in front of the dead woman's lips, and perhaps all examining it with rapid breathing, found a condensation of moisture on it. Neighbours were promptly informed and much excitement produced, so that the coroner decided eventually to hold an inquest. The jury found the prosaic verdict that the woman died at the date and time certified by the doctor. Now, we cannot help feeling that this was a most unfortunate case on which to demand that the system of death certification should be revised, for there seems to have been no really trustworthy evidence that the certificate was not properly granted and perfectly in order. At times of death and grave emergency many people lose their judgment, and nearly all the stories that are reported in newspapers and elsewhere of people being alive when they are supposed to be dead are found, on investigation, to consist of merely unsubstantial substance of which dreams are composed.

Medical Man to refer to the prosecution of Dr. and Town Councillor. Council of that city on the ground of having failed "forthwith" to

notify a case of scarlet fever occurring in his prac-We said at that time that the prosecution seemed to us so extraordinary and so much opposed to all public interests that we suspected that there must be some particular reason behind it all. En passant we may remark that Dr. Dickinson was acquitted by the magistrates on that occasion, and we hope and believe that every medical man accused under similar circumstances certainly always will be. The sequel to this action took place at Hereford Assizes last week, when Dr. Dickinson brought an action for slander against one of the town councillors for a statement made in the course of a speech at the council in October last in connection with the case, and in consequence of which his practice had suffered. Although the councillor, through his solicitor, had apologised, and had also apologised in public at a council meeting, the jury awarded Dr. Dickinson £ 100 damages. This is an excellent result, and we congratulate Dr. Dickinson on having vindicated himself. It is not always that medical men have the determination to go through with an action of this sort in which the worry and risk are so great, but we hope his example will encourage others not to take meekly slanderous statements such as persons in positions of authority like to fling at them. The result of this action will, we trust, be a salutary lesson to people with glib tongues who take advantage of the intricacies of medical practice to abuse medical men who are doing their best to combat the difficulties confronting them.

Vis a Tergo. A good deal has been said of late with regard to the free way some medical men give certificates of disability to members of clubs and friendly societies, and we confess

that we quite understand the difficulty which presents itself to doctors placed in the position in which such gentlemen find themselves. To refuse a certificate entails a careful examination to prevent possibility of error, taking up a far longer time than the club salary is sufficient to reimburse the examiner for, and in the democratically-constituted associations in which the doctor holds his appointment by annual election, to refuse certificates is one of the safest ways of ensuring loss of the appointment. In fact, the doctor is looked upon as a servant of the members who is bound to fulfill their wishes, and not as an independent official to act according to his own judgment. A medical man was summoned for assault last week at Sunderland by a member of a club to which he was medical officer, the allegation being that the member called to ask him to sign two certificates, and that the doctor had (literally) kicked him out of the house. The medical man's defence was that he constantly had to refuse to sign certificates for this man, and had told him not to come to the house again, having two months before told the lodge that the man was well. After some discussion a conference was arranged by the chairman and the summons withdrawn—perhaps the happiest solution of the problem. Reading between the lines, we gather that apparently a technical assault had been committed on a person who deserved sound chastisement, and though one cannot formally approve of the illegality, we think that there would be a great deal less "sponging" if poetic justice could be summarily executed on the weary Willies and tired. Tims who like lodge money better than that they earn with their labour.

#### LEADING ARTICLES.

### ENTERIC FEVER AS A DISAPPEARING MALADY.

ONE of the most striking facts in modern sanitary science is the rapid and more or less complete disappearance of certain zymotic maladies from the United Kingdom. There is no need to elaborate that proposition in addressing the readers of a medical journal; it will suffice to take small-pox as a preventable disease that has nearly gone, and cholera as one that has been altogether banished. As fresh scientific facts accumulate with regard to the natural history of zymotics, there can be little doubt that one by one the process of extermination, beneficent beyond words for the human race, will be extended over the remaining diseases of that class, no matter how hopeless the problem may appear in our present stage of knowledge. regards enteric fever, its persistence, in spite of manifold advances in ætiology, treatment and prevention, has for many years presented a somewhat. disappointing problem to workers in public health. Recent researches, however, have placed in their hands more detailed methods of attacking the specific infection, which must ultimately yield to the outflanking tactics of progressive scientific warfare. Otherwise, the typhoid fever outbreaks mysterious origin that occur from time to time in centres of population where sanitary administrations are of the best possible kind would be more than disconcerting. The medical officer of health of a city that has been thus invaded on several occasions within recent years has issued a document containing on one side an invitation to hospital physicians and others dealing with enteric fever cases to keep a register of convalescents from that malady with a view of securing the attendance of such patients for a period of six months, in order to determine bacteriologically their actual condition as to infectivity. The other side of the document in question contains some clearly written instructions to the patients themselves, and it is suggested that a copy be handed to the latter on leaving hospital. This practical effort at the education of the public through the agency of the medical profession is clearly the outcome of recently-acquired knowledge as to the maintenance and distribution of typhoid fever by continuously-infective persons, who are now generally known as "chronic typhoid carriers." Dr. D. S. Davies, the author of the abovementioned circular, quotes the report of the official inquiry by Lieut.-Colonel D. Semple, M.D., and. Captain Grey, M.D., on enteric fever in India:-"The result of inquiry by the Indian Government," he remarks, "into the prevalence of typhoid fever in the British Army in India has been to confirm very definitely the importance of the 'carrier' cases, and the investigators confidently declare that the problem of typhoid fever prevention amongst the British troops in India consists in the detection and control of the 'carrier' cases, especially in regard to participation in food preparation." bearing of this principle upon the convalescent

enteric fever patients that are constantly being sent home from troops stationed in foreign parts affords much food for serious reflection. In any case, it is obvious that the public should be informed in plain language of the risks that are incurred from convalescent patients. They must be informed that the specific germ of typhoid fever may remain for an indefinite period, and cause relapses even many years after the first attack. The convalescent patient whose intestines retain the infective organism may thus become a continuous and unsuspected centre of infection and transmit the disease far and near. Imagine the possible consequences with a patient of this kind at work in a dairy or on a dairy farm, with the manifold opportunities that must necessarily occur for the contamination of so sensitive a culture medium as milk. Dr. Davies has aptly summed up the position in this respect with the following full and suggestive list :- "Cooks, male or female, dairymen or dairywomen, milk vendors, greengrocers, butchers, fishmongers, provision dealers, workers in cocoa, chololate or confectionery, waiters and waitresses, and the mother who prepares food for the family, form a class of convalescents in which the opportunity of transmission of the disease are very frequent." The provisional rules which he appends are so excellent that we make no apology for reproducing them, in the hope that other medical officers of health may follow this example. They are as follows:—"(1) The hands and nails should be thoroughly washed, first in disinfectant solution, then in soap and water, and well rinsed before touching any foodstuffs, especially milk. (2) After the bowels are opened or the bladder is emptied the hands and nails should be at once disinfected and washed. (3) Strong disinfecting solution should be poured over the stools, &c., before the plug of the water-closet is used or the lid of the dry closet is shut down. (4) When the motions are loose the risk of infection is increased and additional care should be taken. (5) The convalescent should periodically visit the medical attendant, so that the blood, &c., may be tested, and measures may be taken to control the action of the germs. As there is generally no need to deal with the drains, or to disinfect rooms or houses for these special cases, no upset of the domestic arrangements is necessary. (6) In the household where a patient is convalescing from typhoid fever the additional precautions of boiling all the milk or water used for drinking or in the preparation of food should be undertaken, and uncooked foods should be avoided." It is only by the general observance of precautions of this kind that we may hope ultimately to banish from our midst a scourge that has afflicted society from time immemorial.

#### CURRENT TOPICS.

#### Lying Medicines.

An effective method of dealing with the quack scourge is, we understand, being adopted in America by the Food and Drug Department of the Department of Agriculture; at any rate, it has been already put in force in one State. A patent medi-

cine described as "curing croup, whooping-cough, diphtheria, all throat troubles and catarrhal disorders" was taken in hand by the inspectors of the department. Forty-one boxes of this preparation were seized and subjected to analysis, and the report of the medical staff of the board was that it would not cure the diseases mentioned. Consequently the Department ordered the lot to be destroyed, because "it was evident that the preparation was misbranded . . . . for the reason that the statement given on the label that it would cure the diseases mentioned was unwarranted and untrue, and therefore false, misleading and deceptive." This incident raises the question as to whether the sanitary authorities of this country have not already power to prosecute in the case of lying statements made with regard to patent medicines in this country. As administrators of the Food and Drugs Act, could they not prosecute offenders who claim on their labels all sorts of magic powers for their wares, on the ground that the stuff supplied was not of the "quality, nature and substance demanded by the purchaser "? We think that if a man demands a cure for kidney disease and is supplied with a solution of half a grain of potassium nitrate with a little sugar in an ounce of water, a prosecution clearly lies. Will any of our sanitary authorities have the courage to bring a test case?

# The Annual Election at the Royal College of Surgeons, England.

THE election to the vacancies on the Council of the Royal College of Surgeons, in July next, will be of more than usual interest, owing partly to the personnel of the candidates who are competing, and partly to the decision of the retiring councillors each to seek re-election. Thus for the three vacancies created there is, in a sense, no actual vacancy, inasmuch as the rule generally obtains that those councillors, retiring by rotation, who seek re-election are accorded again the support of the majority of the Fellows. The full list of the candidates is as follows: -- Mr. Clement Lucas (1871), Sir Watson Cheyne (1875), and Mr. Mayo Robson (1879)—these are the retiring councillors; Mr. Harrison Cripps (1875), Mr. C. A. Ballance (1882), Mr. Bland-Sutton (1884), Mr. Walter Jessop (1884)—of these Mr. Cripps has already filled a substitute vacancy upon the Council, and last year was a candidate for re-election, but failed to be successful. He is the senior surgeon at St. Bartholomew's Hospital. would be invidious to particularise the claims of these candidates for the coveted honour which they seek, each of whom is well known as a prominent member of the staff of the medical school to which he belongs. In days, however, gone by, the success of a candidate depended, not so much upon his personal position as upon the views which he held in respect to so-called "college politics." The elections were then interesting, and even exciting, the poll taking place under conditions which, in a minor degree, resembled that of a contested parliamentary constituency, the opposing parties being the Council and their friends on the one hand, and the reforming body of Fellows on the other. somewhat remarkable feature in relation to the latter body, known as the Association of Fellows,

was that the majority of its most active supporters were included among the older Fellows of the College, and so it has come about that out of nearly twenty members comprising the former committee of the Association only about four are now alive. Sic transit gloria mundi. College politics, then, for the present, as far as the Fellows are concerned, having become a negligible quantity in respect to the College election, the success of a candidate may be said to be determined, almost entirely, by his personal popularity. But even this will not help him much unless he worries his friends and all who have the power to help him, to accord him their active support. As a matter of fact, success at the poll, even on the part of a favoured candidate, demands the expenditure of much time and trouble, and especially so will this be the case on the present occasion, owing to the somewhat unusual circumstances in which the election is taking place.

#### The German Birth-Rate

THE decrease in the birth-rate in the United Kingdom has not hitherto been attended by a shrinking population, as in the case of France. In foretelling disaster in our own country, pessimists have persistently pointed to Prussia as the one country that, under all conditions, has continued to advance in its birth-rate. Of late, however, a change has come o'er the spirit of the scene, and Prussia appears to be falling under the operation of the laws or altered conditions that have reduced the output of population in so many other countries. We find, for instance, that the total of Prussian births for the year 1907 was about eleven thousand under that for 1906. In 1904 the proportion of births per 1,000 of population was rather more than thirty-five; in 1905 is was thirty-three and threequarters, in 1906 it was thirty-four, and in 1907 thirty-three and a quarter. In Berlin the percentage of births to population is about half what it was thirty years ago, and the country in order to maintain its rate of increase must obviously depend on immigration from other parts of the country. In some of the most prolific parts of Prussia, such as Westphalia, the population has of late become stationary. On the whole, it looks as if Prussia has passed the top of the curve of increase and is now following the down grade shared in greater or less degree by most Continental nations.

# The Irish Medical Benevolent Fund Society.

An interesting letter appears in the daily press from the pen of Dr. H. G. Molony, of County Limerick, with regard to a proposal which he submitted at last year's meeting of the Irish Medical Benevolent Fund Society. Dr. Molony's proposal is, that in view of its deficient funds, the Society should restrict its charity to former subscribers and their families. Dr. Molony's reasons for this proposal, which is at variance with the present course pursued by the Society, are that, first, only a small minority of the profession subscribe to the charity; secondly, that the greater majority of the recipients of its bounty are the very men who have not been subscribers; thirdly, that the annual income is so small that only very small grants can be given.

The objection usually brought forward to Dr. Molony's proposal was voiced at the last meeting by Mr. Lentaigne, President of the Royal College of Surgeons in Ireland, who said that its effect would be to change the Society from a charity into an assurance company. To this Dr. Molony replied-and we think very rightly-that were his proposal adopted, even if a man subscribed one hundred pounds a year to the Society, he would never get a penny from it unless he or his family became destitute. In an assurance company, on the other hand he would get a return on his subscriptions even if he were a millionaire. Molony also instanced the case of one of the Press charities which restricts its grants to former subscribers who become destitute. We can quite understand the reluctance of the Society to change its present and most altruistic mode of conducting its affairs, but the question really is not what has been best and most praiseworthy in the past, but rather what will make the Society most able to carry out its beneficent work in the future. From this point of view we think that Dr. Molony's proposal is well worthy of the careful consideration which it is certain to receive, and that, if adopted, the Society would find that it would result in more subscribers, and hence in a larger income.

# The London and Counties Medical Protection Society.

THE annual report of the London and Counties Medical Protection Society registers a period of steady advance in numbers, in prosperity and in usefulness. The applications to the Society during the year numbered 557, and of these it is noteworthy that 133 were from members practising as dentists. The surplus of income on the year's income is £236 15s. 10d., a sum less than in the two preceding years, owing apparently to increased law expenses. In spite of that fact, however, the balance to credit of the Society stands at some £3,800, as against £3,500 in 1907, and £3,100 in 1906. The Reserve Fund of the Society stands at £4,298 8s. 4d., so that any medical man who contemplates becoming a member may rest assured as to its substantial financial position. One extremely encouraging feature in that respect is the large amount of donations which go to swell the reserve. The cases undertaken by the Society during 1908 were of the usual kind, and included the settlement of various disputes arising out of partnerships and the sale of practices. Some useful work has been done in bringing pressure to bear upon local authorities administering the Midwives Act. Sir Jonathan Hutchinson, F.R.S., still presides over a distinguished body of vice-presidents and council, with the able assistance of Dr. Hugh Woods and Dr. A. G. R. Foulerton as secretaries.

## The Medical Curriculum.

The Report of the Education Committee of the General Medical Council, which was presented to the Council at its recent session, and postponed for discussion to November, will be received with disappointment by those who look for drastic changes in the present curriculum. The Report is conservative in the extreme, and practically proposes to leave things as they are. One important proposal referred to the Committee was that the "preliminary

sciences" should be transferred from the curriculum to a stage preliminary to the commencement of medical study. On this the Committee remark that "all are agreed that the knowledge to be derived from the study of the preliminary sciences is to be considered an essential part of the equipment of a medical man." In this broad statement we can hardly agree. There is no doubt that the study is of high educational value, but the actual knowledge gained by an ordinary medical student of, let us say, biology, is hardly so considerable in amount as to be of any service in a medical man's equipment, much less an essential part thereof. As for its educational value, if physiology and anatomy are properly taught, pure biology is unnecessary. On one point we congratulate the Committee—the refusal to prolong the course from five to six years. At the same time, while definitely deciding that five years should be the length of the course, they suggest such reservation of time for clinical work, apart from the earlier studies, as is likely to swell the course beyond the allotted time. We hope that before the Council makes a final decision in the matter, the entire subject will be carefully considered by the members.

Registration of Nurses
When a deputation waited on the Prime Minister a few weeks ago to press on his attention the question of the registration of nurses, he declared his inability to move until there should be signs of greater unanimity on the subject. The manner in which this answer has been received in Ireland and Scotland respectively shows how far we are from the desired unanimity. In Ireland a mass meeting of nurses, with a live Member of Parliament on the platform, has been held to protest against the procrastination of the Premier. In Scotland, on the other hand, the Executive Committee of the Association for the Registration of Nurses in Scotland has passed a resolution congratulating Mr. Asquith on the stand he made. The real reason of the Scottish opposition is that in Scotland they wish to have their own system of registration independent, at any rate to some extent, of the rest of the Kingdom. In Ireland, on the other hand, they want a uniform system of registration for the three countries, believing that if different registering authorities were appointed, nurses trained and registered in Ireland would be placed at a disadvantage if seeking work in England. For our own part, while admitting the advantages to be gained from a State register in the power of distinguishing nurses of some standing from impostors, we see many objections to the institution of a new order of medical practitioners, possessed of a certain quasi-recognition. The working of the Midwives Act is a warning against any further legislation of a similar nature. We therefore cannot pretend to regret Mr. Asquith's non-committal attitude.

### PERSONAL.

MR. LEONARD A. BIDWELL, F.R.C.S., Surgeon to the West London Hospital, has been elected President of the Chelsea Clinical Society for the ensuing year.

A QUESTION has arisen at Brighton regarding the remuneration of Dr. A. Griffith as Medical Officer of Health for Hove. The present salary is £450 per annum. This, it has been proposed, should be raised but there is consolidated to the salary in the salary in the salary is the salary in the salary in the salary in the salary is the salary in the salary in the salary in the salary in the salary is the salary in the salar to £500, but there is opposition in the Council.

THE Harben Gold Medal of the Royal Institute of Public Health has been awarded by the Council to his Excellency Professor E. von Behring, M.D., of Marburg.

BREVET LIEUT.-COLONEL W. B. LEISHMAN, M.B., M.A.M.C., Professor of Pathology in the Royal Army Medical College, has been appointed by the Council of the Royal Institute of Public Health Harben Lecturer for the year 1910.

DR. J. LUCAS-CHAMPIONNIERE, the famous French surgeon, who is President of the International Congress of Surgeons, visited Cardiff on June 4th, and delivered a lecture to the Medical Society of the city in the oftenness and was the principal guest at the in the afternoon, and was the principal guest at the Society's dinner, whilst during the evening he made a presentation to Mr. Lynn Thomas and Dr. Skyrme on behalf of the medical profession generally.

A DINNER was given in the Liverpool University Club on Monday to the Tropical School of Medicine experts, ten of whom have returned from expeditions this year. Among the latter were Professor Ronald Ross (malaria in India and Mauritius), Professor Sir Rubert Royce and Dr. Wollersham Thomas (yellow fever in the West Indies and Brazil respectively), Dr. J. O. W. Barratt and Dr. Warrington Yorke (blackwater fever in Central Africa), Dr. A. Kinghorn and Mr. R. E. Montgomery (sleeping sickness in Rhodesia), and Dr. W. T. Prout and Dr. A. H. Hanley (malarial fever in

A FINE monument has been erected by the admirers of the late Dr. J. N. Patterson, the oldest medical practitioner in Earlestown. It was publicly unveiled by Colonel J. D. Murray, V.D., of Wigan, in the Cemetery at Newton-le-Willows, last week.

MRS. ANNIE JANE HOLBORN, of Campden Hill, who died in April last, amongst many other charitable bequests, left £5,000 to St. Bartholomew's Hospital.

THE late Mr. Claudius Galen Wheelhouse, F.R.C.S., D.Sc., LL.D. whose death at the age of eighty-two lately took place, left estate valued at £18,590 gross, with net personalty £17,481.

THE summer dinner of the West African Medical Staff will take place on Monday, June 21st, at the New Gaiety Rsetaurant, Strand, London, W. Members of the staff who desire to be present are requested to communicate immediately with Dr. Prout, C.M.G. 78 Rodney Street, Liverpool.

LAST week the Convocation of the University of Oxford approved two decrees accepting from Dr. Theodore Williams £2,500 to establish two scholarships in physiology, and £2,500 to establish two scholarships in human anatomy. The Vice-Chancellor proposed the decrees and expressed the gratitude of the University to Dr. Williams for his liberal bene-

SIR FELIX SEMON, K.C.V.O., Physician Extra-ordinary to the King, is retiring from practice—and the occasion will be marked by a complimentary banquet to be given him by his professional and other friends, on Friday, July 2nd, at the Whitehall Rooms, Hotel Metropole. The organisers of the banquet are anxious to found a lectureship or scholarship in his name to be a record of his scientific work as one of the founders of the British School of Laryngology of the founders of the British School of Laryngology. Mr. Henry T. Butlin, F.R.C.S., D.C.L., will preside at the dinner, and all communications with regard to the Testimonial Fund or application for seats at the banquet should be addressed to the hon. secretaries: Alfred Mond, Esq., M.P., 35 Lowndes Square, S.W.; P. Watson Williams, Esq., M.D., 4 Clifton Park, Bristol; H. J. Davis, Esq., 8 Portman Street, London, · E \_\_

# A CLINICAL LECTURE

ON THE

## TREATMENT OF BRONCHO-PNEUMONIA. (a)

By EDMUND CAUTLEY, M.D.Cantab., F.R.C.P.Lond.,

Physician to the Belgrave Hospital for Children and to the Metropolitan Hospital.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

GENTLEMEN,-Broncho-pneumonia is one of the commonest diseases of infancy. About half the cases occur in the first year of life, a third in the second year, and one-tenth in the third year; leaving only about one-fifteenth for the remainder of life. This distribution is important from the point of view of prophylaxis. Several of the cases are primary, but quite two-thirds of them are secondary. You might divide them up into groups according to their severity, their anatomical distribution, or their main characteristics. Thus, one class of case is fatal in from 12 to 36 hours; a less severe type lasts for a period varying between 6 and 10 days; a third type is prolonged for 3 or 4 weeks, and occasionally for 6 or 8 weeks; a fourth type is cachectic in character, with little or no fever, and very often no evidence during life. On anatomical grounds one speaks of a capillary bronchitis, in which no physical signs of consolidation are found, though you will be practically certain to find small patches after death; or there is a lobular pneumonia, in which there are definite small patches of bronchial breathing; or these lobular patches are aggregated into larger masses involving the whole lobe, or nearly so. Any one of these conditions may be either unilateral or bilateral. You can also divide them, according to their main features, into those in which the obstructive symptoms predominate, others in which the cardiac symptoms are most pronounced, a third type in which the nervous symptoms are very characteristic, a fourth type in which there is asthenia, and a fifth characterised by profound toxæmia.

In speaking of the treatment of this disease I can only speak generally. I must leave you to judge what is appropriate for the particular case.

First, with regard to prophylaxis. The most important consideration is that the child should be put under the best conditions of life from the day it is born. In other words, it must be brought up on the breast in preference to the bottle; must be suitably clad, not exposed about the legs, buttocks and arms, as delicate children often are; and it must be brought up under suitable conditions of hygiene as regards ventilation and bathing. Furthermore, it is of the utmost importance to guard babies up to the fourth or fifth year of life, from those infectious diseases to which broncho-pneumonia is so commonly secondary, namely, by keeping them from exposure to the infection of measles, whooping-cough and influenza. You must also attend to any naso-pharyngeal catarrh which may be present, and give great attention to the treatment of even mild bronchitis and to all forms of gastrointestinal trouble, for many attacks are a terminal event in cases of ileo-colitis.

With regard to nursing, it is important that when a child is seized with an attack of broncho-pneumonia the room should be kept at an appropriate temperature, viz., 60° to 65°, or in the case of a weakly or premature infant, 65° to 70°. The open-air treatment is extremely useful, especially in secondary cases, where the attack is not due to exposure to cold. By this I mean the child should have a free supply of pure air, though not necessarily every kind of atmosphere. Certainly it does not mean reckless exposure to raw, damp, or foggy air. The child should be protected also from strong winds. You can

provide a sufficient supply of pure air in the room by keeping the windows open, and warming the atmosphere by fires, protecting the child from draughts by screens. The child should wear a flannel nightdress and cotton-wool jacket, unless the temperature dress and cotton-wool jacker, unless the temperature is very high. In a bad case you will see the effects of open-air treatment very quickly; the child becomes less restless and irritable, the face is less flushed, the lips less cyanosed; both pulse and respiration rates fall, the appetite improves, the child sleeps better, and the strength is well maintained. I know of only two definite contra-indications to a large supply of open-air for this complaint, namely, convulsions and laryngitis. In these cases you have to exercise even greater precautions than those I have mentioned. In all cases of broncho-pneumonia the diet is the next factor of importance. The disease is a very depressing one, especially in toxemic cases and those which are secondary to infectious disease, and there is marked liability to intestinal disorder, notably tympanites. So you must give a diet which is nutritious and readily digestible. Breast feeding is best, and if the mother is nursing the child, it must be continued. Failing that, you must rely upon milk, suitably diluted, peptonised if the child does not digest it, and sweetened with cane sugar, or with lactose if there is diarrhoea or tympanites. It can be further strengthened by the addition of protein, in the shape, for instance, of plasmon or other dried casein preparation. You can also give veal or chicken broth, and plenty of water. In the early and acute stages you had better be content with regular small feeds, composed of the foods I have mentioned. Such children are very constantly over-fed, and suffer in consequence; for if they get gastric or intestinal distension, the diaphragm is apt to be pressed up and the breathing and action of the heart to be interfered with. At the very onset it is justifiable in some cases to give an emetic, but on the whole, my experience of emetics is not very satisfactory. They are only justifiable in the case of robust infants who are suffering from great mechanical obstruction on account of the excessive secretion into the bronchial tubes. But emetics are very depressing. If you give one, I think the best is powder of ipecacuanha, 5 to 15 grains, according to the age of the child, repeating it in ten minutes, and again if necessary; and giving a liberal supply of water. It is better, on the whole, than tartrate of antimony,

of which one-sixth to one-third of a grain is the cose. At the onset of an acute attack with fever, much good can be done by means of hydrotherapeutic measures. A bath at a temperature of 90° to 95° reduced down to 30° or even 75°, given for a period of five or six minutes, may sometimes cut short an attack. In giving it, sit the child in the water, support its back with the hand, and do not let the water rise above the level of the lower ribs. Sponge it freely all over, then wrap it up in a warm blanket, and put it back to bed. It is advisable to give some stimulant before such a bath. A bath at a temperature of 90° to 95° may be given night and morning, or as often as every three hours, if there is a temperature above 102°. At the onset of an attack, especially in the congestive cases, poultices may be very useful. There is too great a tendency nowadays to discard poultices and to speak of them with contempt, choosing bot fomentations in preference. But the latter are more difficult to apply successfully, more liable to make

<sup>(</sup>a) Delivered at the Polyclinic, Chenics Street, London, W.C., on Monday, May 3rd, 1909.

the bed wet, and to chill the child subsequently. You can use a poultice of linseed, linseed and mustard (one part of mustard to eight of linseed), bread, or bran. But see that the poultice is sufficiently large for the child to lie in, and that the poultice does not extend on to the front of the chest or abdomen. it does, it will interfere with breathing. Change the poultices frequently, and do not allow them to stay on until cold. Usually it is good to start with a poultice every twenty minutes for a couple of hours, and then put on a cotton-wool jacket. See that the poultice is applied at the proper temperature. It is not uncommon among the lower classes to apply fomentations and poultices too hot, causing much pain, blistering of the delicate skin, and severe scarring afterwards. No doubt pain acts as a counter-irritant, but it is rather a cruel kind. It is better to rely upon some simple kind, such as camphorated oil, turpentine liniment, mustard leaf, or-a very useful preparation which is not widely enough known—electra cloth. This is a cloth which has been impregnated with Chillie paste, and is damped and placed on. The Chillie paste, and is damped and placed on. degree of irritation varies with the degree of dampness, and the duration of the application. If you want stronger measures, use a mustard pack or a hot mustard bath.

With regard to drugs, you can sometimes do good in the early stages by the administration of belladonna, in doses of 4 or 5 minims of the tincture, or ‡ grain of the extract every three or four hours, according to the age of the child and the severity of the case. Belladonna is given for three reasons: To reduce the bronchial spasm, as a cardiac and respiratory stimulant, and to diminish the amount of secretion in the bronchial tubes. If it is going to produce any good result it will do so in a few hours, say twelve. If it does not cause a definite result in twenty-four hours, I think it should be discontinued.

It is advisable to combine the belladonna with diuretics and diaphoretics. If you can induce the skin to act freely, you will relieve the congestion of the lungs, and also the toxemia, which is sometimes a very pronounced feature. Occasionally one meets with cases which have been treated with aconite, the doses being usually 1 to 1 minim, combined with a little alcohol, and given every hour for twelve to twenty-four hours. I am not very much in favour of it, for aconite is a powerful cardiac depressant, and in broncho-pneumonia I think it is advisable to avoid such depressant drugs as aconite, ipecacuanha, antimony, and coal-tar products; or, if used at all, they should be in only robust infants, and with very great care. Tincture of veratria is also used in small doses every two hours. It is difficult to make certain whether drug treatment has anything to do with the result, as many cases subside very quickly without any special treatment, whereas others will go on and become more severe, no matter what measures you adopt. Another drug which is very useful in early cases and in all stages is carbonate of ammonia, which I do not think is given sufficiently freely. When one is called in to see such a patient, which is generally not until twelve to twenty-four hours have elapsed from the onset, a very good combination to give is I grain of carbonate of ammonia, a little iodide of potassium or ammonium chloride, tincture of nux vomica, syrup of tolu, and chloroform water; the doses being proportioned to the age of the child. Usually for a child under one year of age, you will find that 1 to 4 grain of carbonate of ammonia is given. But I do not hesitate to give a grain, even to a child six months of age, and I have not seen it cause any ill effects. Later on, if you want to increase the secretion and render it less tenacious, you must rely on the carbonates and iodides of sodium and potassium, ammonium chloride, and benzoate of soda. And in addition, you can give stimulating expectorants, more especially tincture of squill and tincture of The first of these is a most valuable drug, for not only is it an expectorant, but a powerful cardiac tonic, almost as good as digitalis. Vinum ipecac. and vinum antimonialis have, in my experience, very

little effect unless they are given in depressant doses, and depression ought to be avoided. If you use any coal-tar products, let it be phenacetin, in doses of 1 to 3 grains every two to four hours, according to the age. I use it especially in nervous cases in which there is very high fever. It relieves those symptoms, and also headache if present, though the latter is not common, especially where the fontanelle is open. Antipyrin may be used, but antifebrin is too powerful a drug. Quinine should not be given by the mouth, as it is liable to upset the digestion. If you give it at all, give it by the rectum, in doses up to 5 grains, dissolved in water. Keep the bowels acting regularly but without setting up diarrhea, and for this it is best to rely on small frequent doses of calomel or grey powder. Strong purges are apt to set up fatal ileocolitis, and should be avoided. And, for fear of upsetting the intestinal tract, avoid giving cough mixtures, especially those made up with syrup. One is constantly asked in these cases whether one should make use of the bronchitis kettle. Under some circumstances, it is beneficial, but, under others, injurious. If the atmospheric air is very dry, and the cough hard and dry, then the steam does good by moistening the air and loosening the secretions. If, on the other hand, the atmosphere is moist and cold, and the secretion in the lungs is profuse, then I think that inhalations from the steam kettle are distinctly injurious. If you use a steam kettle, it is generally advisable to put the child in what is called a half-tent; if you use a whole tent you will keep out too much fresh air. Remember the vapour from the steam kettle is apt to condense and become cold when you have the windows open, and then the child inhales nasty cold, damp vapour. Inhalations do good undoubtedly, but it is simpler to give inhalations of turpentine, eucalyptus, creosote, or thymol, by sprinkling the drug on a sponge, lint, or flannel, and holding it in front of the child's nose and mouth for five or ten minutes every two hours. I think much of the benefit of turpentine liniment is derived from the vapour inhaled. An inhalation may increase the secretion, or it may decrease it, according to the kind used. With regard to special complications, I must mention first of all, tympanites and severe diarrhea, for they are the commonest complications, and they are dangerous ones. In the treatment of tympanites, it is advisable to starve the child entirely, unless extremely debilitated, giving nothing but water for a time. If the mischief is gastric, wash the stomach out with a solution of bicarbonate of soda, 4 grains to the ounce of water. If the tympanites is due to intestinal distension, the passage of a rectal tube, or, still better, an enema of asafetida and water, will lead to the evacuation of the wind. You may also give fairly large doses of nux vomica, or liquor strychninæ, in order to stimulate peristalsis. Severe diarrhea is treated on dietetic lines, and generally that is sufficient. Occasionally, it is necessary to give small doses of tincture of opium, in order to check the excessive peristalsis. Of course, this may make the child drowsy, and increase the pulmonary congestion by interfering with efficient respiration, so it is a matter of grave responsibility to prescribe opium for these patients.

In the treatment of very high fever, you can apply cold compresses to the chest every two hours, or use the cold or tepid bath, applying cold to the head at the same time. For the nervous symptoms, which may or may not be associated with high temperature, you must adopt cold or heat—cold if there is a high temperature, heat if the temperature is subnormal. A hot bath, with moderate fever, affords more relief than a cold bath does. A cold bath should not be given if the temperature is below 102° F. In the case of sudden collapse, which may arise from cardiac failure, either due to rapid distension of the heart, from toxæmia, or mechanical obstruction in the lungs, or the sudden collapse that is due to atelectasis, you have to use very free stimulation. There is nothing equivalent, in the worst cases, to the mustard bath at a temperature of 85°, or a mustard pack. Usually

these mustard baths are given at too high a temperature, namely, at 100°, but the effect of the mustard is reduced by temperatures above 85°. In giving a mustard bath, the child is immersed up to the neck, the head being free, and the neck protected, so that the child does not inhale the mustard vapour. After the child is taken out of the mustard, it should be washed rapidly and well with water at a temperature of 90° to 95°, and wrapped in a warm blanket. In addition, give inhalations of oxygen, or of amyl nitrite; in all bad cases of broncho-pneumonia, you should have a cylinder of oxygen at hand. Then, too, you can give by the mouth stimulants very freely. Brandy is the best form, or you can use strychnine, nitro-glycerine, camphor, or caffein. If the case is definitely due to cardiac failure, large doses of carbonate of ammonia, sal volatile, ether, or nux vomica may be given; or you may give nitro-glycerine by mouth or subcutaneously, in doses of 1-500th of a grain. Strophanthus and digitalis are also useful; and very often they are given in the early stages to guard against this dilatation of the heart. If you give either of these drugs when the dilatation is fairly fully established, I think you will do more harm than good. If the dilatation of the right side of the heart is very definite, sufficient to cause dyspnæa and some cyanosis, before giving drugs such as digitalis and strophanthus, you ought to apply one to three leeches about the level of the right nipple. Leeching relieves the right side of the heart better than any other method it is possible to adopt. After you have brought about this relief, your drugs will be much more efficacious.

Where one has to deal more definitely with failure of respiration, you sometimes get good results from the injection of atropine, in doses of 1-1,000th to 1-500th of a grain, combined with strychnine in doses of 1-400th to 1-100th of a grain, and caffein, 1-10th of a grain. Such cases should also be encouraged to breathe deeply by inducing frequent crying and by alternate hot and cold douching of the chest.

Where there is much passive congestion at the bases of the lungs, dry cupping is of great use. This method of treatment is not used nearly sufficiently. A very great point in the nursing of these babies, and more especially in nursing wasted babies in hospital, is that they should not be allowed to lie, as they so often are, on their backs nearly all day long. That causes congestion at the bases, and increased difficulty of respiration. In hospitals, it is impossible for the nurses to nurse the babies as much as they can in private, but the nurse should prop the child up in a sitting posture occasionally, and place it first on one side and after a time on the other, and occasionally in the prone position.

In the convalescent stage you have to remember there is a great liability to recurrence and hence you have to adopt much the same hygienic precautions which you would in a case of incipient tuberculosis. Patients are likely, especially if their broncho-pneumonia was secondary to whooping-cough, to have a dilated right side of the heart, and will suffer in consequence from anæmia and shortness of breath. The dilatation may not be recovered from for several months. Some of them are left with a chronic cough, which is best treated with creosote or terebene preparations. The ordinary convalescent should be treated by cod-liver oil, iron preparations, arsenic, and small doses of quinine. If possible, choose for these patients a warm and dry climate, and in hot weather a high altitude.

But, remember, much of this treatment is often quite unnecessary, for mild cases of broncho-pneumonia, especially if primary, will recover under the simplest methods of feeding and nursing. In cases complicated by mechanical obstruction from excessive secretion in the lungs, you have to pay chief attention to relieving this congestion by means of drugs and counter-irritation to the chest. If the toxemic symptoms are pronounced, you have to rely upon alcohol and strychnine, and upon elimination. So

you have to treat every case according to its severity, and proportion your remedies according to the type of disease.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Prof. Leon Delmas, M.D., of the Faculty of Medicine of Paris. Subject: "The Treatment and Diet in Infantile Castro-Enteritis."

### ORIGINAL PAPERS.

# SOME RECENT RESEARCHES ON THE

# FUNCTION OF THE NON-AUDITORY EAR.

By R. H. WOODS, M.B., F.R.C.S.I., Surgeon for Throat, Nose and Ear to Sir Patrick Dun's Hospital, Dublin.

(Concluded from page 581.)

EWALD conducted experiments which demonstrate the fact that these eye movements have their reflex origin in the internal ear. He laid bare the right horizontal semi-circular canal of a pigeon, and made a small opening into the bony canal at some distance from the ampulla. This opening he plugged, so as to stop the flow of the endolymph in the membranous canal. He then made a second opening between the first one and the ampulla, and laid bare, but did not wound, the

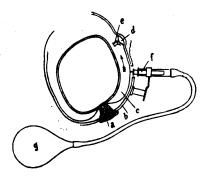


Fig. 6.—Diagram of Ewald's experiment (Bárány).
a. Plug in s.c. canal. b. Bony canal. c. Endolymph in membranous canal. d. Crista and e. Cupula ampullaris. f. Piston. g. Compressible air bag.

membranous canal. He then fixed a tiny piston worked by air-pressure from an elastic bag, so that when the bag was compressed, and the piston driven against the canal, the endolymph moved in the direction of the ampulla. He found that compression of the bag was followed by a slow movement of the bird's head and eyes to the left in the horizontal plane, while by relaxing the bag and drawing the piston away, a slow movement of the head and eyes in the opposite direction took place. The first movement corresponds to a right, and the second to a left, nystagmus. In the same way, by experimenting with the other canals, he was able to induce movements of the head and eyes in the plane of the canal with which he was dealing. He thus proved in a very elegant way the truth of Flourens' law. It should here be remarked that nystagmus in man differs in one important respect from that of animals. In man the nystagmus is purely ocular, while in animals the head partakes of the movement as well.

Considering the minuteness of the membranous canal, and the great friction of the endolymph against its walls, the amount by which the crista moves must be most minute, and in the same way the tug exerted on the maculæ by the inertia of the statoliths must be immeasurably small, but this need not prevent us from

admitting such stimuli to be adequate, when we consider how small a quantity of energy in the form of light or sound suffices to stimulate the retina or the cochlea.

Since every movement of the eyeball is a purely rotatory one, we must, for purposes of reference, speak of them as taking place in one of the three chief planes of the body, or some combination of them. But since the front of the eyeball is the part practically observed. we only speak of the movement as it affects, say, the cornea or iris. Thus nystagmus in the horizontal plane is called horizontal. Nystagmus in the sagittal plane is called vertical; while nystagmus in the coronal plane is called rotatory. In horizontal and vertical nystagmus the whole front of the eyeball moves in the same direction, and the nystagmus derives its name from the direction of the quick movement; but in rotatory nystagmus, while the upper part moves in one direction, the lower part moves in the opposite. The direction of rotatory nystagmus is said to be that of the quick movement of the upper part of the eyeball. Thus, if the quick movement is in the direction of the hands of a clock in the patient, he is said to have rotatory nystagmus to the left, and conversely.

We can produce experiments in man parallel to Ewald's by turning a patient in a rotating chair. If the body be rotated round a vertical axis with the head erect, the horizontal canal is the only one stimulated,

and pure horizontal nystagmus results.

In the same way rotation in the plane of any other canal will induce eye movements in its plane. A short consideration of the matter will show that the effect of rotation on the endolymph in any given canal will depend on the relation of the canal to the plane of rotation. When these planes coincide, the effect is a maximum, but as the plane of the canal gradually differs from the plane of rotation, the effect on the endolymph gets less and less, until, when their planes cut one another at 90, it becomes null.

The influence of rotation on each canal can be pre-

The influence of rotation on each canal can be predicted when we find out the angle at which the plane of rotation cuts that canal, and it will vary as the cosine of the angle. Now, since we have three canals, each at right angles to the others, every plane of rotation, no matter how situated, will have its corresponding combination of canal effect, and the effect for each plane will differ from that of every other plane, and will be represented by the formula—

E=f (cos.  $a+\cos$ .  $b+\cos$ . c), where a, b, and c are the angles made by the canal planes with the plane of rotation. By this mechanism the nystagmus evoked by rotation in any plane is always in that plane in other words, the plane of rotation of the head will always be the plane of nystagmus.

It may be useful to give a few examples to illustrate the effect of rotation in nystagmus. If when seated in a chair revolving to the right the head is erect, the nystagmus will be right horizontal. If the head showed forward at a right angle, so that the eyes look downwards at the centre of rotation, the resulting nystagmus will be purely right rotatory.

If the head is inclined to the right shoulder at an angle of 90°, and the patient is turned to the right, the clane of the nystagmus will be vertical with respect to the body. Intermediate positions give intermediate results. If the head be bent forwards at an angle of 45°, the nystagmus during right rotation will be partly

right horizontal and partly right rotatory.

There is one case where the movement is a little confusing on account of the nomenclature. During right rotation with the head erect we get, as we know, horizontal nystagmus in the same direction. If the head be bent back by 90°, so that the face looks upwards, we still get nystagmus in the direction of rotation, but since the absolute direction of the quick movement of the eyes is against the hands of a clock on the ceiling, it will be with the clock in the patient, and is by definition left rotatory nystagmus; in the same way, after right turning, we get right rotatory nystagmus. If a position between these two be chosen, say where the patient looks upward at an angle of 40°, we get during right rotation right horizontal and left rotatory nystagmus, while after right rotation we get left horizontal and right rotatory, and the horizontal element

will be accentuated by looking to the left, and the rotatory by looking to the right.

If a person has one labyrinth destroyed, it is found that, if he is rotated first in one direction and subsequently in the other, the duration of the after nystagmus evoked is different in the two cases.

Suppose the left labyrinth destroyed, and the patient is first rotated to the right, the cupula of the right horizontal canal is distorted towards the vestibule during rotation, and away from it when rotation is stopped. Conversely, after rotation to the left the distortion is towards the vestibule. Now the latter is found to be considerably the stronger and more lasting of the two reflexes. In other words, right nystagmus has its dominant cause in the right ear, and left in the left. For convenience of reference, we may say that, when the crista is distorted towards the utricle, it is positively stimulated, and when towards the canal negatively, the positive stimulus being the stronger. Thus the rotatory chair may be used as a means of testing the relative health of the two labyrinths. Deaf mutes and others in whom both labyrinths are destroyed do not react to rotatory or other stimulation.

There are, of course, but three dimensions, and

therefore but three pairs of dimensions or planes in which rotation can take place, but in each plane rotation can take place in two directions-viz., with and against the hands of a clock. There are therefore six ways in which rotation can happen, and in each plane the corresponding canal is stimulated more actively on one side by rotation in one direction, and on the other side by rotation in the other direction. In all cases it is found that the stimulation is greater when the crista is distorted towards the utricle than towards the canal. Hence it is of importance that when a canal is stimulated positively on one side, the functionally corresponding one on the other side should be negatively stimulated. In this way the two horizontal canals are functionally paired, and the anterior canal of one side is paired with the posterior canal of the opposite side. Professor Crum Brown has drawn attention to the very elegant point that the existing arrangement of the canals on both sides of the body is the only possible one whereby this condition can be satisfied while preserving bilateral symmetry.

From what has been said it will be seen that by the rotating chair we can test the relative health of the two labyrinths, for when brought to rest after left turning, the right labyrinth is chiefly in function, and after

right turning the left.

Rotatory nystagmus can hardly, if at all, be controlled by the will, while horizontal nystagmus is greatly shortened if the patient looks at or "fixes" an object.

If horizontal nystagmus is to be observed, it must be done by putting a pair of opaque spectacles on the patient; the reaction is then unhindered, as there is nothing for the eyes to fix.

It has long been known that syringing the ear with too cold or too hot water was liable to cause giddiness, and even vomiting. The explanation is still new, and offers a striking confirmation of the theory of the function of the semi-circular canals.

If, while the head is erect, a stream of cold water be run into the right ear, it is found that rotatory nystagmus to the left, the opposite side, takes place after a minute or so. The cold water causes cooling of the vestibule at its outer side—i.e., in the neighbourhood of the ampulæ of the anterior and horizontal semi-circular canals. This causes the endolymph to condense, and therefore to fall; the horizontal canal lying at right angles to the movement will be unaffected, but in the anterior semi-circular canal there will be established a convection current moving as if the head were rotating in the direction of the hands of a clock—i.e., to the left, and therefore we get a rotatory nystagmus to the left, the opposite side. In the same way syringing with water above the temperature of the body causes nystagmus to the same side.

Since, in obedience to gravitation, movement of the endolymph under influences of heat or cold must always be in a plane vertical with regard to the earth, the nystagmus evoked will always be in the same plane. The name by which it is described will, of course,

vary with the position of the head with regard to the earth. Thus, if the patient lies flat on his back, and the right ear be syringed with cold water, he will get a nystagmus still vertical as regards the earth, but it will be caused by the horizontal canal, and will be a left horizontal nystagmus, since the endolymph moves and the ampulla is distorted as if the patient were being rotated to the left, round an axis run through the centre of the body. A moment's consideration will show that if the nystagmus is evoked by caloric means, the external auditory meatus must always lie in the plane of the nystagmus; hence caloric nystagmus can never be evoked in the sagittal plane.

For this test cold water is better than hot, for two reasons. In the first place, people tolerate temperatures many degrees below the normal, while the upper limit is very soon reached, and, of course, the greater the difference of temperature between the water and the body the greater the effect. Secondly, when used in the upright position the cupula is positively stimulated.

As before mentioned, if the eyes are made to look in the direction of the quick movement, the nystagmus is increased, while if they are made to look in the opposite direction, it is diminished or suppressed. Now it will be found that with the increase of nystagmus the sensation of giddiness is increased, and conversely. This points to the nystagmus as the cause of the giddiness, and here we have a simple remedy for that distressing symptom. When we find out the direction of the nystagmus—i.e., of the quick movement—the patient should be directed to look to the opposite side. years ago, at one of the bazaars in Dublin, there was an ingenious—some said a diabolical—contrivance, called a "Topsey-Turvey House." This was a canvas room, with pictures, fireplace, and windows painted on the walls. A steel bar passed through the middle of the room, on which were fixed a table and chairs, where the people who had paid for admission were seated at a convenient distance above the mock floor. When the seats were occupied, the room was revolved round the steel bar as an axis, with the result that the most dis-tressing giddiness was produced in return for the money paid. Here nystagmus of vestibular character—viz., rhythmic, was caused by ocular means, without any disturbance of the vestibulary apparatus. This furnishes us with a proof that the giddiness may entirely depend on the nystagmus. Needless to say, sitting on a fixed chair with closed eyes would not have evoked it. I knew of a lady who could not take a walk near the sea without suffering from sea giddiness, and the story goes that she was once actually seasick on an openwork iron pier. This must have been the result, in a neurasthenic, of giddiness, the result of ocular nystagmus from looking at the motion of the waves. I have found it a valuable plan when at sea to stay on deck somewhere amidships, and, keeping as vertical as possible, fix my eyes on the horizon. Nystagmus is thus avoided, and no contradiction between the observations of the eye and labyrinth takes place. The only influence uncontrolled is that of the maculæ, but it is probable that this is not so important.

The vestibulary apparatus is susceptible to toxic

influences.

In my own case, long before I knew the reason why, I noticed that, when feverish, I always evoked a feeling of giddiness by looking sideways, and I can now give a fair guess as to my temperature by the discomfort occasioned by such a look. The explanation presumably is that the toxines cause both the fever and the labyrinthine irritation, and that the nystagmus, and therefore giddiness, is evoked by putting the eye muscles in tension. There can be little doubt that the disturbance of equilibrium under alcohol is due to its toxic effect on the labyrinth. I have observed spontaneous nystagmus to both sides, i.e., to the right on looking to the right, and to the left on looking to the left, under what was described by the patient as quite a moderate dose.

If, therefore, poisonous matter circulates in the blood, and by affecting the labyrinth gives rise to giddiness, giddiness is a possible result of toxæmia. And since the stomach is the natural portal through which poison gets into the body, it is no wonder that one of the most prominent effects of giddiness is vomiting, for by this mechanism the presumed source of

disturbance is eliminated. We thus see that the brain in sea-sickness is really hoaxed by the vestibule, through being incapable of distinguishing between a mechanical and a chemical cause of giddiness, the result being that the last meal, however innocent, is foolishly heaved overboard for a Jonah.

The chief accompanying phenomena of nystagmus

are the following:-

It appears to the patient as if external objects were moving in the direction of his nystagmus. Thus with right rotatory nystagmus external objects appear to him to fall to the right. The reason for this is that the quick movement is too rapid for any ocular impression to be made, while during the slow one, with the eye, as we say, rotating towards the left, a procession of images is formed on the retina, such as would happen if the objects were actually falling to the right.

He feels as if he were moving in the same direction, that of the quick movement. For though, in the example taken, the objects appear to be falling to the right, they do not change their relationship to him; his natural impression, therefore, is that he is falling with them. To this it must be added that the conditions in the labyrinth are the same as if he was actually falling, and in so far as the impression of this reaches the cortex, it must contribute to that sensation. Feeling himself to be falling to the right, his natural impulse is to correct this, and so his actual movement is in the direction opposite to the quick movement.

If severe in degree it occasions vomiting. This is less true of horizontal than of vertical or rotatory

nystagmus.

The vestibulary apparatus may be stimulated electrically by a continuous current of about 5 or 6 m.a. through the temporal region. If the cathode is placed in front of the tragus, nystagmus toward the same side is evoked. This method is not of much utility.

Mere air pressure transmitted through the external auditory meatus will also act as a stimulant, but in order that this pressure should be sufficient, some pathological change in the bony capsule of the internal ear must have taken place, such as abnormal mobility, or defect of the foot of the stapes, or an erosion by chronic middle ear disease into some part of the labyrinth.

Owing to our better understanding the physiology of the labyrinth, it is now possible to effect some classification of its diseases, though it must be admitted that our knowledge of the subject is still in its infancy. Complete destruction of the labyrinth apparatus may result from trauma, such as fracture of the base of the skull, purulent infection from middle ear disease, labyrinthine hæmorrhage, syphilis, or acute diseases such as whooping-cough, or without discoverable cause.

When such a lesion occurs in a young child, the prostration and vomiting resulting from the giddiness frequently mislead to a diagnosis of a "gastric attack."

From whatever cause arising, acute destruction of the labyrinth is characterised by complete loss of hearing, severe nystagmus to the sound side, and consequent disturbance of equilibrium, giddiness, and vomiting. The irritability, if tested, will be found to be diminished or abolished. The patient lies on the sound side, thus avoiding the necessity of looking towards that side, and thus increasing the giddiness. In two or three days the giddiness, nystagmus, and vomiting subside, but neither the irritability nor the hearing power ever come back.

Inflammation of the labyrinth may take place without destruction. Serous labyrinthitis, as it may be termed, runs a slower course. At first it has for itsonly symptom spontaneous nystagmus to both sides. Then systagmus to the diseased side, with giddiness and increased irritability, supervenes. In the third stage the nystagmus is toward the sound side with diminished irritability, the hearing remaining positive all through. The disease then usually retrogresses through the same stages until normality is reached at a time varying from a week to a month, but in one case under my cate the affection progressed until after a year the hearing power became entirely lost on that side, and the irritability also lost, the giddiness and spontaneous nystagmus disappearing gradually. This patient came under my observation late in the course of her case, and treatment had no effect. In

another case the patient, otherwise healthy except that she had atropine rhinitis without fœtor, became absolutely deaf on both sides after three months. During this time she suffered from the most distressing giddithis time she suffered from the most distance. After ness and vomiting accompanied by nystagmus. After two months' daily treatment with pilocarpin hypothesis have been became almost normal. The question as to how destruction of one vestibule can cause nystagmus is not easily answered, but we may regard both labyrinths as sending some stimuli towards the centre, which neutralise one another. In this way, with increased irritability, we get nystagmus to the diseased side, while when the irritability is lowered the opposite stimulus being uncompensated, the nystagmus is to the sound side.

Nystagmus from intracranial causes has long been known, and it is important to be able to differentiate

between the two classes.

If there are other intracranial symptoms present, such as palatal and facial palsy, as happened in one of my cases, the diagnosis is easy.

If, with an unirritable labyrinth, we have spontaneous nystagmus to the diseased side, it may be assumed that the labyrinth is healthy, and the lesion is inside the cranial cavity, for a destroyed labyrinth cannot cause nystagmus to its own side.

If with an unirritable labyrinth we have marked spontaneous nystagmus to the opposite side, it may, of course, have its origin in the labyrinth of the affected side, but, if so, it must be the first effect of destruction of that labyrinth, and must cease in a day or two, while if the origin is intracranial it will persist with the

# THE NATURE OF SICKNESS AFTER ANÆSTHESIA, WITH SUGGESTIONS FOR ITS TREATMENT, (a)

BY J. BLUMFELD, M.D.CANTAB., Senior Anæsthetist to St. George's Hospital; Hon. Anæsthetist to St. Mary's Hospital, London.

THE subject of sickness after anæsthesia has a practical interest for all those who, like members of this Society, are responsible for the condition of patients after operation, whether they have themselves either given the anæsthetic, performed the operation, or done neither the one nor the other. I make no apology for bringing this subject before you, although it might be thought that an anæsthetist has little opportunity of seeing the after-results of his handiwork, and that, though he is the main instrument in causing sickness when it occurs, yet he has little opportunity of seeing in what cases it does occur or of treating it when this is the case. To me, however, the after-results of anæsthetics have a particular interest, and I have long been in the habit of finding out what has happened to a patient afterwards or of seeing for myself. In hospital, of course, it is perfectly easy to observe for oneself, and in private cases when this is not convenient one can generally be furnished with a reliable account from the practitioner or surgeon in charge, or else from the nurse. The private cases are in this matter perhaps more important than hospital cases, first because the subjects in whom after sickness is a real obstacle to a favourable result are more common in private practice than in hospital; and secondly, because the hospital patient is less upset by sickness afterwards, and is more apt to take it as a matter of course. This brings me to the question of the prevalence of sickness, and here I would say that writers on the subject appear to me to over-estimate the proportion of cases in which sickness follows an anæsthetic. The various statistics that have been compiled are not of much value, for this reason, that just what is meant by sickness is not always clearly stated.

Here are some figures collected in the Report of the Anæsthetic Committee, British Medical Association, IQOI:-

2r,585 cases ... 3,406 vomiting in various degrees. ČHCl₃ ... 11.6 per cent. vomited \*\*\* ... 24.7 22 Gas and ether ... 15.01 A.C.E. ... 18.4

(a) Paper read before the Chelsea Clinical Society, April 20th, 1909.

Marcus Gunn, in 4,056 ophthalmic cases, found that 1,902 vomited. Summing up available figures, T. D. Luke finds

CHCl<sub>3</sub> gives 15 per cent. A.C.E. ,, 25 ,, E ,, 40 ,,

In this paper, when I speak of sickness after anæsthesia, I mean any vomiting or retching which occurs after the patient has become conscious. Before consciousness has returned any such act is, of course, a source of no discomfort to the patient, and is, moreover, being never of a prolonged or very violent character, often an advantage rather than the oppo-site: after the use of ether, for instance, it is a common occurrence and one not to be prevented or regretted for the patient to vomit, just after the anæsthetic is withdrawn, the mucus and saliva that has been swallowed. This is so little to be deprecated that some administrators, indeed, urge that the process should be imitated in all cases where ether has been used, by washing out the stomach with water directly after the administration has stopped. Indeed, one authority recommends prolonged lavage of the stomach for about half an hour, for example, three to six gallons of water being used, a pint at a time. This is poured into the stomach and syphoned out. He believes that in this manner all the ether can be washed out of the patient's blood. I have never tried that method, nor do I think it is rational. If ether were excreted only by the stomach there would no doubt be much to be said in favour of this stomach washing. The fact is, however, that ether and other anæsthetics are excreted not largely, if at all, by the stomach, and our efforts at freeing the body of them as soon as their work is done should not be primarily directed to the stomach at all. In alluding to treatment, however, I am putting the cart before the horse, and must first discuss the causation of sickness and see to what extent we know the nature of that which we shall endeavour to treat. Firstly, then, with re-gard to the stomach we have to remember that the mucous membrane does not secrete unless stimulated. The condition is different from that which holds, for instance, in the case of the kidneys, from which urine escapes in a regular, though intermittent, manner along the ureters and into the bladder. In the stomach such secretion takes place only on stimulation, and the best stimulus is the natural one, i.e., food. The nerves of the stomach come from the vagi and splanchnic plexuses, and end beneath the cells of the mucous membrane; they have not been traced into the epi-thelial surface. It is conceivable that anæsthetics which are being carried by the blood might, when they reach the stomach circulation, stimulate the nerve endings and cause secretion, just as happens in the case of the salivary and buccal glands. We should then have the unusual fact of the stomach secreting, although there was nothing in it. Physiology teaches us that this is not, however, a very unusual occurrence, and that the nervous mechanism of the stomach may be excited and secretion aroused by impressions upon the central nervous system, as, for instance, the sight or smell of food to a fasting man. The stomach, sight or smell of food to a fasting man. The stomach, in fact, can be excited to secrete either locally by the presence of food or through the central nervous system, as in the case referred to. Anæsthetics might cause secretion in either of these ways, but, on the other hand, they might inhibit the process, as we know they do in the case of secretion of urine and, indeed, in the case of metabolism generally. Similarly with the act of vomiting we have to recognise both a local and a remote causation. Vomiting may we know be a remote causation. Vomiting may we know be caused by direct action upon the mucous membrane of the stomach or by impulses emanating from the vomiting centre in the medulla oblongata. This centre is closely related with the respiratory centre, and like this centre it may be excited in a reflex manner by stimuli applied to peripheral nerves as, e.g., when vomiting is induced by tickling the fauces. The vomiting of intestinal obstruction is also of this reflex nervous nature, and not a regurgitation, for it may be prevented by division of the mesenteric nerves, and it occurs even when the bowel is empty. In these cases

of reflex vomiting, another familiar example of which is the vomiting associated with the passage of calculi, the afferent impulses reach the centre by vagi and splanchnic branches. Now, the centre may be excited, not only reflexly, as in the foregoing instances, but just as may the wall of the stomach, it may be excited directly by the action upon it of certain drugs. over, it is excited in some cases of disease within the cranium; and, lastly, it may be excited by impulses reaching it from higher parts of the brain, as in cases of vomiting from smell, taste, or violent emotion. Emetics like tartar emetic appear to act directly on the centre, for they produce vomiting when a bladder has been substituted for the whole stomach. Others, such as mustard and water, act by irritating the gastric membrane. There is another way in which vomiting may arise that I have not yet mentioned, this is in connection with circulatory depression, as in the vomiting that so often terminates a fainting attack. Taking into consideration these various ways in which vomiting may be caused, and bearing in mind the action of anæsthetics as we know it to have effect upon the nervous system we are brought to this conclusion: Vomiting due to an anæsthetic drug which is in circulation throughout the body must arise either (1) by the direct stimulant action of this drug upon the nerve endings of the stomach, or (2) by its direct action upon the vomiting centre, or (3) by causing circulatory depression to such an extent as to bring about cerebral anæmia. Now, with regard to the stomach, we have a certain amount of evidence, both clinical and experimental, that though the condition of this organ plays a part in the causation of vomiting from anæsthetics, yet it is not the chief organ concerned. We know from experimental observation that during anæsthesia the mucous membrane of the stomach is saturated with the anæsthetic, brought to it, of course, in the circulating blood. Thus both the mucous membrane and the glandular and muscular tissues of the organ are subjected to the action of the drug. The nerves also are under its influence. We know from clinical evidence that the condition of the stomach as regards fulness or emptiness plays a part in the occurrence or not of after sickness. At the same time it must be stated that one authority at least disputes this and maintains that vomiting is no more likely to occur if a patient is fed shortly before operation than if he is not. The experiment is one that is made for us occasionally in the case of emergency operations, and my own experience is that when the stomach is full at the time of administration vomiting invariably occurs either during or just after the administration of the anæsthetic. Indeed, one of our chief reasons for anæsthetic. Indeed, one of our chief reasons for believing that post-anæsthetic vomiting depends mainly upon a central effect and not upon the stomach itself is our incapacity to control it even by the most thorough care of the stomach. Thus we may ensure by careful dieting, regulation of the bowels, and a proper interval after the last food and before the anæsthetic that the stomach is really empty at the time of operation. We may then by washing out the stomach with water before return of consciousness remove any secretion that has taken place in the stomach during anæsthesia by reason of the stimulating effect of the anæsthetic upon the mucous membrane. We should now, if the stomach alone were responsible, get no further vomiting, provided that nothing were put into the stomach to excite secretion. Unfortunately, the facts do not bear out our hypothesis, and such treatment as this, although it diminishes the number of cases in which vomiting occurs does certainly not abolish its occurrence.

Allied to this treatment by washing out the stomach is a measure based on the same idea that, viz., of removing the anæsthetic which is presumed to be excreted into the stomach. This measure consists in the systematic administration of large quantities of water before operation. Four ounces of cold water are given every four hours until two hours before operation, then 10 oz. are given and, again, 10 oz. half an hour before operation. In two series of cases treated in this way there were, in the first series of 35, four cases of vomiting. S. E. Gunn in the second series of 40 cases found that twelve vomited in the ordinary way; nine did not vomit at all, and twelve vomited

slightly, or only once. He states that those who had had anæsthetics previously pronounced themselves much more comfortable when this treatment was adopted. Such figures as these are obviously of little value without further details. One wishes to know what operation is performed in each case and what anæsthetic is employed. Both these factors have an influence on the occurrence or not of vomiting. tain operations, particularly in my experience those upon the kidney, and upon the pelvic organs in women, are more likely to be followed by sickness than others. I may mention here that years ago Lord Lister stated his belief that operations dealing with Lister stated his belief that operations dealing with the ovary were especially liable to be followed by vomiting. The different behaviour of different anæsthetics in this respect is familiar to you all. It is the common opinion nowadays that CHCl<sub>3</sub> causes less sickness than E, and it is interesting in this regard to notice that when the latter drug was first introduced, one of the chief advantages claimed for it was the diminished frequency with which it inhelation the diminished frequency with which its inhalation was followed by sickness as compared with the commonness of the latter after chloroform. The explanation of this discrepancy lies in the method of administration. Ether by an open method, which was the original old way, now once again extolled, is certainly followed less by sickness than are the newer closed methods, whatever may be the other disadvantages belonging to the original method of administering the drug.

administering the drug.

The true facts as regards CHCl<sub>3</sub> and E in this connection are, I think, these: vomiting is more often absent altogether after the use of CHCl<sub>3</sub> than it is after the use of E; but, on the other hand, really serious vomiting, going on, for instance, for days, is almost always the sequel to chloroform anæsthesia, and scarcely ever to that from ether. I cannot enter here upon the vexed question of the so-called delayed CHCl<sub>3</sub> poisoning, which would require a long paper by itself, but it is, I think, quite rational to regard all cases of vomiting after chloroform as being of the same nature as these pronounced cases, the effect in one case being slight and transitory, in the other more pronounced and long-lasting. With ether the typical vomiting occurs early and is soon over. This corresponds with the volatility of the drug and with the much less extent to which we know it to act upon the tissues than is the case with chloroform. There are some persons who are made sick by chloroform although they are not by ether, although in accordance with what I have said before the opposite is more

Occasionally it may not really be the difference in the drugs that is responsible, but the necessary difference in the way they can be administered. I mean that in the case of CHCl<sub>3</sub>, anæsthesia cannot be induced without the patient being conscious of the anæsthetic. Whereas in the case of ether by preliminary use of nitrous oxide this can, of course, be accomplished.

often the case.

An interesting example of this occurred to me not long ago. The patient, a lady, æt. 44, had undergone an iridectomy, for which she took chloroform given by an expert anæsthetist. The vomiting that followed was so violent and prolonged that to it was attributed a cataract of the lens which followed on the operation. It became necessary to operate for removal of this cataract, and the surgeon anticipated so much difficulty from adhesion that he did not think it wise to attempt the removal under a local anæsthetic. The patient assured me that if she smelt chloroform it would make her sick, and I have no doubt it would have done, for she was not at all a fanciful or neurotic person. I promised her she should smell nothing whatever except a little pleasant scent. This was accordingly sprinkled into the facepiece of a Clover, and she was fully anæsthetised by nitrous oxide, followed by just enough ether to tide over the transition to chloroform. The operation, which was a difficult one, was done under chloroform, and lasted 17 minutes. The natient did not vomit at and lasted 17 minutes. all, and was, except for a few minutes after the return of consciousness, when she thought she was going to be sick, quite comfortable throughout conJUNE 16, 1909.

valescence, and highly pleased with herself. This was a case, if one may judge by the bare facts, in which the method of administration, and particularly quick-ness and pleasantness of the induction of anæsthesia were essential factors in avoiding after-effects.

I have mentioned as a third possible cause of post-anæsthetic vomiting, circulatory depression. Depres-sion of the circulation, accompanied by a certain amount of diminished blood supply to the brain, occurs in the course of most kinds of anæsthesia; moreover, the act of vomiting is, as we all know, generally directly preceded by a pallor which indicates the low ebb at which the force of the circulation has arrived. Yet it would, I think, be difficult to maintain that this condition is the primary state which causes postanæsthetic vomiting. In the first place patients under ether may vomit, as we must all have seen at times, whilst their circulation is actually in-so to speakfirst-rate going order; a full pulse, a deep red face, and a vigorous respiration up to the very point of vomiting; showing that a depressed circulation is not immediately to blame in the matter. Moreover, patients who have been ill long, and are anæmic, weak, and with very poor circulatory power often go through even long of erations without any subsequent vomiting. We may put this cause aside then also, and regard post-anæsthetic vomiting as a central effect produced mainly by the direct action of the anæsthetic drug upon the vomiting centre. Another argument in favour of this view is the consideration that, broadly speaking, patients vomit only when they are lightly under an anæsthetic. They may vomit in the process of induction if this takes place toe slowly; they may vomit during anæsthesia if this is of too light a degree, and thirdly they may vomit when, no more being administered, they are beginning to recover from the effects of the drug. Now this course of events corresponds with what we know of the action of anæsthetics upon other parts of the central nervous system. Their general action in this respect is at first to stimulate, and then with increased anæsthetic effect to deaden nervous action. So too with the vomiting centre; at first a stimulation, resulting in vomiting if the increased action is not rapidly proceeded with, which results in paralysis of the centre. During recovery we reach again the stage of stimulation with consequent vomiting. If we agree then that post-anæsthetic vomiting is a central effect, unfortunately we are no nearer the pertinent question "why do some patients vomit after are the pertinent." "why do some patients vomit after anæsthetics, and ethers not?" Putting aside the various considerations which I have alluded to, such as the nature of the operation, of the anæsthetic, the duration of the anæsthesia, the previous preparation of the patient, there are still one or two points to be mentioned before we confess that we cannot further answer this question. A practical point is the extent to which the patient is moved when operation is over. It is astonishing how constantly the moving of a patient from operating table to bed, if cerelessly performed, and particularly if the head is allowed to flop about, will be immediately followed by vomiting. Moreover, I have been told by a well-known surgeon who had himself to undergo several operations that in the semiconscious stage of early recovery he felt quite comfortable, unless an attempt was made to alter his position in bed—then he was invariably sick. This is a point in which, I think, nurses are not sufficiently schooled. They should be told most emphatically that when the patient is back in bed he should not be shifted an inch unless for some important reason until consciousness has completely returned.

The position in which he is placed when put back to bed is thought by some to be of great importance. Some surgeons attribute a great deal to the sitting position. The patient after an abdominal operation is put back to bed sitting almost bolt upright, a special arrangement of support beneath the thighs being employed to keep him there in addition to pillows behind the back and shoulders and head. It is held, I believe, that in this position anything inside the stomach is more likely to pass on through the pylorus than when the patient lies down. Certainly if sickness actually occurs it is far less strain on the sitting than on the lying person. Supposing now that all the

points referred to, preparation, proper choice of anæsthetic, minimum quantity of the anæsthetic, careful movement of patient, proper position and quiet careful movement of patient, proper position and quiet in bed after operation, have all been attended to in two different persons, it may yet happen that one of them will be entirely free from sickness and the other vomit abominably. How can we explain this? At cresent, gentlemen, I believe we cannot, and we talk of different idiosyncrasies. No doubt we shall discovere come day what the manning of such idiosyncrasis. cover some day what the meaning of such idiosyncrasy is, and it may be that a tangible chemical difference will be elucidated along the lines of work which various investigators are pursuing in connection with delayed chloroform poisoning. At present clinically we have a few empirical facts that guide us in practice, but the scientific bearing of which we cannot yet discern. For instance we know that those who have been accustomed to considerable amounts of alcoholic drink over a considerable period of time are our best patients from the point of view of aftersickness. They seem to have a real immunity against this effect of anæsthetic drugs. They are intmical to their action in every way as we all know from the difficulty that may be experienced in anæsthetising such individuals, and the extreme liveliness of their reflex excitability throughout anasthesia. But what is the secret of this immunity we do not know. If we but did we might be able to confer it temporarily upon our abstemious, but after anæsthetics, unhappy patients.

Again we know that vomiting is quite unusual with very old patients, and also with very young ones. Generally speaking young adults are bad subjects from the point of view of vomiting afterwards-often with these subjects, such as boys about 15 years old, for example, there is much mucous secretion; when that is the case, to wash out the stomach once before recovery lessens the tendency to vemit.

To speak for a moment of exceptional instances of vomiting. In my own experience they have occurred only in one class of subject. This is the neurotic emotional unstable woman of about thirty who has led a fast life. In this class of subject I have twice seen vomiting after operation so severe and so long lasting that the chances of its leading to death from exhaustion seemed very grave indeed. In one case exhaustion seemed very grave indeed. In one case there had been a laparotomy with removal of double pyosalpinx-that is to say an operation after which vomiting might be expected. The operation had not taken very long, however, and was well borne. Vomiting started almost as soon as consciousness returned, and there was not that delay which is usual in the delayed CHCl<sub>3</sub> cases; water by the mouth was allowed, and a rectal injection was given containing 10 grains of aspirin. I had asked that this might be given early after operation because the patient was obviously, before taking the anæsthetic, of a very highly strung, nervous kind, and I think aspirin by the bowel after anasthesia often ensures a long space of time for quict recovery in these people. However, in this case it apparently did no good, for the vomitin this case it apparently did no good, for the vomiting continued so frequently and so violently that on the fourth day the gentleman in charge of the case asked me if I would go and see the patient with him. I found her not so exhausted as I expected, but in a very restless talkative condition, and with a pulse over 100. There was nothing to incriminate the abdomen, as a cause of the vomiting. We treated her with injections of 1/6 gr. of morphia every two hours, and after three injections there was no further vomiting, whether in spite of, or because of the injections, it does not seem possible to say.

Now in the other case to which I referred, which was throughout very similar, there was this interesting

addition, viz., that the patient had several anæsthetics from all of which she recovered only after appearing to be in extremis from vomiting, and one of these anæsthetics was a short administration of nitrous oxide and oxygen—this, I think, points very strongly to the nervous nature of such cases as these. In many cases I believe it is good practice to give an enema containing a large dose of bromide before consciousness has fully returned. The practice of giving morphia beforehand in order to reduce after sickness I have not found successful. The most rational way

to treat and prevent after-sickness, according to present knowledge, appears to be to promote in way the elimination of the circulating anæsthetic. That is to say the patient should be kept warm that the skin may act freely, and renal secretion should be helped. For this purpose saline enemata are, I believe, of great value, and one should be slowly introduced as soon as the patient is back in bed. In some hands large quantities of saline are introduced slowly under the skin for long periods of time after severe operations, and it is claimed that not only is shock diminished in this way, but after sickness immensely less frequent. Whilst elimination is thus going on the less put into the stomach the better. There is no call for anything at all except through thirst, and this is little trouble if enemata or subcutaneous injections are used. Washing out the mouth with glyco-thymolin or lemon juice and water is pleasant for the patient, and helps to allay feelings of thirst. On the theory that post-anesthetic vomiting arises through cerebral ædema calcium lactate to lessen transudation of the blood serum has been recommended. I have had no opportunity of testing this. Preventive treatment with glucose, based on chemical theories explaining delayed chloroform poisoning has been given a trial at St. George's Hospital; the results do not show any marked alteration of the ordinary percentage of cases of after-sickness. in estimating the value of any method a very long trial is necessary, for the number must embrace many examples of all kinds of subjects. At present there is no doubt that the patient's personal peculiarity, on whatever it depends, is a very determinant factor in the question of after sickness. Nevertheless, gentlemen, I hope I have indicated that much may be done by proper selection and administration of anasthetics, and by proper treatment before and after, to alleviate what is often an extremely distressing, and what will in the future, I hope, be a far less common complication during recovery from anæsthesia.

### THE STATE AND OTHER RELATION-SHIPS OF MODERN DENTAL SURGERY. (a)

By H. R. F. BROOKS, L.D.S.EDIN., GLAS., AND I., Hon. Dental Surgeon to the Horton Infirmary.

THE deplorable state of the teeth of civilised races has long been recognised; the evil is an increasing one and at the present time is so general that there are few who escape its ravages. A variation from the economy of Nature at once so important and so well-nigh universal, could not fail to have significant results beyond any temporary or individual inconvenience. I do not propose to discuss the influence of deterioration of the teeth upon the evolution of the race, or to do more than suggest the converse hypothesis, but without entering the realms of speculative theory at all, it may be asserted that there are few diseases of which an unhealthy mouth may not be a direct or contributory cause. Dyspepsia, with the many ills that follow in its train, at once suggests itself as a well-known example, but there are other of the more common and serious diseases whose dependence upon a faulty condition of the organs of mastication is not so generally recognised. The mouth, even in a normally healthy state, offers a favourable medium for the conveyance of pathogenic organisms, but the chances of their development and infection of susceptible tissues are infinitely increased by any departure from this condition. The possible agency of dental caries in the production of tuberculosis, for instance, cannot be disregarded, and care of the teeth is one of the necessary preventive measures to which the Local Government Board (or the suggested Minister of Hygiene) should direct attention in any future official circular on the subject. In this country it is largely owing to the persistent efforts of the British Dental Association that notice is being attracted to the grave

effects of dental caries upon the health and physique of the nation.

The examination of large numbers of school children (and in this connection the excellent work of the School Dentists' Society should be mentioned) has conclusively shown that those with decidedly defective teeth are almost invariably amongst the most unhealthy. On the other hand, and to prevent any confusion of cause and effect, experimental denta-treatment has been followed by a marked improvement in the general condition—individually of the children. and collectively of the particular school. portant data are afforded by the wholesale rejection of army recruits because of defective teeth, and the acknowledged gain to the State resulting from the tentative arrangements for dealing with some of these cases; by the report of the Inter-Departmental Committee on Physical Deterioration; and by the action of the Board of Education leading up to, and following the medical inspection of school children. When to these are added the conclusions of the Sub-Committee of the Education Committee of the London County Council on Medical and Surgical Treatment (of which the Hon. Secretary of this Association was so useful a member) it is manifest that attention is being irresistibly drawn to this difficult problem, although its

full significance is by no means realised even yet.

"Knowledge comes but wisdom lingers." Still, the recognition of an evil is the first step towards its remedy. Speaking here this morning to an audience of experts, I need not say that there is a remedalthough it must be confessed that there are difficulties in the way of its application. The individual who is able to pay the fees can be treated—very successfully treated—by the trained and skilled dentist; a few—unfortunately a very few—of the poorer members of the community may be assisted by generously reduced charges, or by Dental Aid Organisations (of which we are to hear something during these meetings), of by hospitals and dispensaries. There remains a still greater proportion of the comparatively or the very poor, for whom there is no provision by the charity of either profession or public. Amongst them are a relatively large number of those to whom, more than any, sound teeth and healthy mouths are essential the physically unfit, the ill-fed, the badly housed and clothed—those who fall an easy prey to the disease associated with poverty and dirt—those whose impoverished and hereditary taint will be transmitted with the most reckless prodigality and improvidence. to succeeding generations. If, as in the history of pasticivilisations, not only the happiness, but the veriexistence of a nation, may be threatened by the deterioration of the units composing it, there is cause-nay more, there is urgent need—for intervention the State, even although the possible issue be State Dentistry in some shape or form.

The systematic inculcation and practice of simp. methods of hygiene would do much to limit the evi and such instruction must always form part of an suggestions for its cure, but, apart from this, there and there can be, no alternative to the adoption measures for treatment by properly qualified dentists It is frequently stated, and stated with some appear ance of reasonableness, that our numbers are hopeless. insufficient for the purpose, and that the entries a the dental schools offer no immediate prospect of an satisfactory adjustment, but it is probable that, : both respects, the resources of the profession a greater, and might be more extensively utilised the seems to be generally supposed. There is one dire tion, at any rate, and that along the line of least : sistance, in which they should be adequate to desuccessfully with a large amount of incipient diseaand very greatly to restrict many of its cumulative effects. The children, of course, offer this most remising field for organised dental service.

For the operation of any definite scheme, whether it take the form of school clinics, or recognised denisurgeries, or one method, State or rate aid, or possibly appropriate the composition of the composi

support, seems inevitable.

If I have emphasised the necessity for some national

<sup>(</sup>a) Abstract of Inaugural Address delivered before the Annual General Meeting of the British Deutal Association, Birmingham, May 29th, 1909.

provision for the care of children's teeth, it is because, whilst there is no physical evil so prevalent as dental caries, or possibly so diverse in its consequences, there is probably none the treatment of which, if undertaken in its early stages, would secure results so important and comprehensive, at a cost so comparatively small.

Amongst those prospective results may be included not only a decisive check to the forces of deterioration, but a sure, if gradual, racial improvement. It is true that degeneration is ever a more easy and rapid process than regeneration, that facilis descensus averni, but it is quite possible that in the course of long periods of time a return to type might be secured, and that the dental tissues, which in man's earlier history were the most enduring of the human organism, might again outlast the individual. Need I say that this ideal future, in which the dentist will be only a memory of a troubled past, is yet far distant.

There is another direction in which the interests of the public and the dentist alike call for the intervention of the State. Those important issues which depend upon the treatment or neglect of dental disease make it absolutely essential that, so far as the State can determine, the treatment shall be the best that modern science can provide—that it shall be given by those, and by those only-whose qualifications have satisfied the standard recognised by law, as well as by common sense, as needful for registration.

Unfortunately it is notorious that dentistry has always offered a lucrative field for the enterprise of the ubiquitous charlatan, ever alert to take advantage of the proverbial ignorance and credulity of the public in all matters affecting its own health, and prepared with every variety of subterfuge to imply that he is what he is not, and what he may not call himselfa person specially qualified to practice dentistry. Recognising this evil of whose extent and consequences it has unequalled opportunities to judge, this Association urges the necessity for appropriate means to deal with it.

In proportion to the greatness of the legacy of science and opportunity which we in these early days of the twentieth century enjoy, are our present responsibilities, and our obligations to those who come after. It may be there are few of us who can hope to make any notable contribution to the wealth of this inheritance; the share of most of us may be no more—it certainly should be no less—than the honest attempt to discharge the duties of our ordinary everyday work. But, if this be all, the part is surely no ignoble one; to serve mankind, to relieve its sufferings, to lessen its ills, to help it forward to the ideal existence, these are privileges of the calling we have chosen. And it is as we most untiringly pursue those objects, as we most faithfully discharge our duties to those who entrust themselves to our care, that we shall most nearly approach the goal of our professional life, that we shall most closely realise the aspirations of our Association, both of them so well expressed in the watchword of this city and in the motto of this University: "Forward"—Per ardua ad alta.

### OPERATING THEATRES.

ROYAL FREE HOSPITAL.
CASE OF COLOSTOMY. — MR. WILLMOTT EVANS operated on a man, æt. 53, who had been admitted suffering from chronic intestinal obstruction due to malignant disease of the rectum. He had been suffering from gradually increasing constipation for more than a year. The motions had become compressed, or pipe-like, and both with and between the motions blood and mucus were passed. He had no definite pain, but he had found it necessary to take an increasing amount of aperient medicine frequently. He had had two or three attacks of almost complete obstruction, but he had been relieved by copious enemas. He had steadily lost flesh, though the total amount of loss appeared not to have been great. On examination per rectum a hard mass was felt some

three inches from the anus; it extended round the whole circumference of the bowel wall, though it was more marked posteriorly. The lumen was much contracted, and only the tip of the finger could be introduced for about a quarter of an inch, but after that the opening became still smaller. In the hollow of the sacrum some ill-defined masses could be felt, which were probably enlarged lymphatic glands. There was no evidence of any secondary growth in the liver or elsewhere. As Mr. Evans did not consider the local growth to be removable, he decided to per-form the operation of colostomy.

The patient having been prepared and anæsthetised, an oblique incision two inches and a-half in length was made on the left side of the abdomen, parallel to Poupart's ligament and an inch and a-quarter above it, the upper end of the incision being placed on the line leading from the anterior superior iliac spine to the umbilious. The incision was deepened until peritoneum was reached; this was then opened and seized with forceps. As no bowel presented, the forefinger of the right hand was introduced and swept across the iliac fossa from within outwards. It came in contact with a portion of bowel which was drawn out of the wound. This was recognised to be the sigmoid flexure by the presence of the appendices diploicæ and longitudinal muscular bands. It was somewhat distended, but it was easily drawn out of the wound. As much bowel as possible was drawn down until the upper part of the sigmoid was reached. The remainder of the bowel was returned, leaving a loop of some three or four inches outside the body. An opening was then made in the meso-sigmoid, close to the bowel, the obvious vessels being avoided. A silk stitch was then passed through the skin of one edge of the wound, then through the opening in the meso-sigmoid, then to the skin on the other side of the wound, after which it was passed back through the opening in the meso-sigmoid and tied so as to bring into contact the two edges of the skin underneath the bowel. A few other silk stitches were also inserted so as to attach the bowel to the edges of the wound, the stitches being chiefly passed through the longitudinal muscular bands. A piece of "protective" was then placed over the bowel, and the wound dressed with gauze in the usual way.

Mr. Evans said, as for the diagnosis of this case, there was no room for doubt; the clinical history of a gradually increasing constipation, with a narrowing of the diameter of the motions, pointed conclusively to a constriction of the bowel, and the presence of blood and mucus in the motions made it probable that the stricture was due to a growth. Digital examination confirmed this diagnosis, and gave additional information that the growth was carcinomatous in nature. The question then arose: Would it be possible to remove the portion of affected bowel? He thought this could not be done, because the large size of the growth and the apparent involvement of the lymphatic glands in the hollow of the sacrum rendered it practically certain that the growth was much more widespread than even it appeared, and that any attempt at its removal would fail, for it would not be possible to remove it completely, and early recurrence would only follow. The only alternative was colostomy. Mr. Evans was in favour of performing this operation at a comparatively early date of the disease, for he thought that if it were postponed until complete obstruction occurred, the results were much less satisfactory. Moreover, he thought that by providing a higher outlet for the fæces, the rapidity of the growth of the carcinoma in the rectum was retarded, as it was no longer subjected to the irritating influence of the passage of the fæces. Nowadays the only operation of colostomy performed is the left inguinal. was desirable, he considered, to make the incision fairly high up, as had been done in this case. method he had employed to prevent the bowel slipping back was the most convenient, for, so long as the stitch held, the bowel could not return into the abdomen. It was desirable not to make too large an incision through the abdominal wall, for large incisions favour prolapse. Some years ago Herbert Some years ago Herbert Allingham suggested dividing the bowel, suturing the

upper portion to the abdominal wound, and closing the lower portion and returning it into the abdomen. The objection to this practice was that it was extremely difficult to determine which was the upper and which was the lower end; in fact, the mistake of confusing the two was made in one case in which Allingham's method was employed, so that this form of the opera-tion is no longer performed. It was best to defer the opening of the bowel to the third day after the operation. If the distension is very great it may be opened at once, a Paul's tube with a rubber tubing being em-If the opening be postponed till the third day, good adhesions have formed. No anæsthetic is required, and the redundant portion of bowel easily snipped away with scissors. An efficient colostomy truss must be worn, and it is desirable that charcoal and salol be given by the mouth, so that the fæces are less malodorous than they would otherwise be. The diet also should be so chosen as to give rise to as little decomposition as possible. If these precautions be taken, patients have little discomfort, and do not regret that the operation has been performed.

The bowel was opened on the third day, and the patient was able to leave the hospital about a fortnight after the operation, wearing a truss.

OPERATION FOR STRANGULATED HERNIA. - MR. JOSEPH CUNNING operated on a man, æt. 76, who had been admitted with the following symptoms: A right inguinal hernia, from which he had suffered for many years, had become irreducible fourteen hours before admission. There had been neither pain nor vomit-ing; the bowels had not acted since that period. On examination a swelling the size of a large pear occupied the scrotal and inguinal regions; it was tense, curred yet, there were the most incontrovertible signs of strangulation present—namely, that the hernia was tense, irreducible, and without impulse on coughing. The tensity of a strangulated hernia was due to the effects of gradual compression of intestine, which resulted in ædema of that structure, and later in the presence of free fluid in the hernial sac. the presence of tensity in an irreducible hernia was the most certain sign known of strangulation. In older times it was taught that collapse and fæculent vomiting were the classical symptoms, but it was extremely rare nowadays to see a patient who had been allowed to go unrelieved for a sufficiently long period for these symptoms to arise.

As a prolonged attempt to reduce this rupture had been made before admission, it was not thought advisable to make any attempt at reduction except by operation. Another reason for this decision was, that the hernia had been strangulated three weeks previously, although on that occasion it had been possible to reduce it

An incision was made over the inguinal canal and extending inwards and downwards for about an inch beyond the external ring. The sac was exposed and opened, a quantity of blood-stained fluid being found within it. The situation of the constriction was found to be a thick, indurated external ring. This was divided with a hernia knife after passing a hernia director, the direction of the cut being vertical and The strangulated portion of small intestine could then be pulled down, and a careful examination made of it. With regard to this, Mr. Cunning demonstrated that there was no ulceration at the line of constriction, and that, although the bowel was of a deep purple colour, it retained its polish, and therefore gangrene had not occurred. Under these circumstances it was safe to replace it within the abdomen. This was accordingly done. The sac was next isolated as far as the internal ring, ligatured, and removed. The internal oblique and the conjoined tendon were then sutured to the deep part of Poupart's ligament behind the structures of the cord. The cut margins of the external oblique were then sewn together in front of the cord, the skin around being subsequently brought together by a continuous suture without drainage.

Mr. Cunning remarked that the rules laid down as to the division of the constriction applied more especially to cases in which it had taken place at the internal ring. The direction of the division did not so much matter when the strangulation had occurred at the external ring. At the internal ring the incision should be made directly upwards, so as not to risk wounding the deep epigastric artery. In the present case the site of the strangulation was owing to the external ring having been much inflamed and thickened, the result of the constant wearing of a truss. For this reason, when more bowel was forced down, the hardening of the external ring had produced strangulation.

### TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, MAY 7TH, 1909.

The President JOHN LENTAIGNE, in the Chair.

BIER'S METHOD OF TREATMENT BY HYPERÆMIA.

MR. R. ATKINSON STONEY read a paper on the above subject. After mentioning the various forms of hyperæmia, he said he would confine his remarks to passive hyperæmia, produced by means of the elastic bandage and suction glasses, more especially in the treatment of septic inflammation, rather than in tubercular disease, as in the treatment of the latter type of cases his experience had been neither extensive nor promising. He described the method of applying the elastic bandage and the suction glasses, laying special stress on the necessity of not producing too great a degree of hyperæmia, as in that case serious harm might be done. He gave the following rules for the application of the bandage:—(1) Place it on the limb as far from the site of the disease as convenient.
(2) Wind it round a broad surface of the limb, to prevent local pressure and pain. (3) Do not bandage with sufficient force to weaken the pulse distally. (4) No pain should be caused in the diseased part, rather any existing pain should disappear. (5) The distal part should be bright or dark red, not blue, and should be warmer than the corresponding part on the opposite limb, not colder. (6) The bandage, for all opposite limb, not colder. (o) the bandage, for all except tubercular cases, should be left in position for two periods of 8 to 11 hours, or one period of 16 to 22 hours out of the 24. In the case of the suction glasses, ordinary aseptic precautions should be ob-A glass of sufficient size should be chosen to leave a margin of 1 in. or more around the inflamed part or opening, to prevent strangulation or compression of the lips of the opening. Pain should not be produced. And, especially where the cup was placed over a superficial bone or firm membrane, excessive pressure should not be used, for fear of sloughing of the parts. Some cases were briefly described illustrating the use of both these forms of application of passive hyperæmia in various conditions.

The PRESIDENT said he had been deterred from the use of the method by the unsatisfactory results got in the hands of some surgeons, but Mr. Stoney had helped to explain some of those results. He had recently been converted to its use for boils, but he had seen a great number of cases of tubercular disease which had deteriorated by the treatment, and in some cases he could not satisfy himself that the dissemination of the tuberculosis had not been in some way due to it.

Mr. L. G. Gunn said he had tried the treatment in cases of knee and wrist trouble, but found it impossible to produce any degree of congestion without pain. He was therefore not surprised at getting no good results. He thought French and English people, and more particularly Irish people, probably felt pain more acutely than the Germans, which might explain the differences in results.

the differences in results.

Mr. W. I. DE C. WHEBLER confessed the same experience as Mr. Gunn, but in cases such as gonor-

Dr. ELLA WEBB inquired as to the effect of the use of appliances advertised for putting on to the cervix of the uterus.

Mr. PEARSON said that the use of the band would seem to lead naturally to the increase of pain, as it was chiefly a matter of tension, but the suction apparatus, by reducing atmospheric pressure, might produce an initial diminution of pain.

Mr. STONEY, in reply, said the worst results had been got by Bier in the knee-joint, for some reason which he could not explain. He did not suggest the treatment in any case where better results, or quicker equal results, could be obtained by operative means. It was in tubercular cases that the greatest difficulty was found in producing the correct degree of hyperæmia. He had no experience of the instruments mentioned by Dr. Webb. The question of tension was difficult to deal with. It was, however, easy to understand that pain, which might be due to irritation of the nerve terminals by toxines produced by organisms, might be relieved by the congestion causing a flow of blood and lymph, and producing a dilution of the toxins.

#### POST-OPERATIVE TETANUS.

Mr. Gunn read a paper on this subject.

The President said the paper was one of the most valuable which had been read before the Academy. He could imagine no more appalling catastrophe to happen a surgeon than to have a case, or series of cases, of post-operative tetanus. He could not help keeping to the belief that the catgut must have been responsible. It was curious that in every case in which the catastrophe had occurred, catgut had been used. It would be important to know what methods of sterilisation had been employed. He had himself been using the iodine catgut for some time, but if he was threatened by the terrible phantom of possible tetanus he would be inclined to give up catgut altogether

he would be inclined to give up catgut altogether.

Dr. KATHERINE MAGUIRE said she had been in attendance on one of the cases mentioned by Mr. Gunn. It was not a case of hysterectomy alone, but was combined with ovarian tumour, and quantities of thick catgut had been used. She thought the case was probably hopeless from the first. She knew that the patient could not have contracted the sheep disease mentioned by Dr. Richardson in his paper, as the patient had come from a part of England in which it was absolutely unknown. The time of the dissolving of the catgut was the time of being infected, and that had made it impossible for her to exonerate the catgut.

Mr. Pearson recounted the clinical history of one of the cases alluded to by Mr. Gunn, in which the patient died about 28 or 30 hours after the onset.

The Secretary said it seemed difficult to get over the fact that in every single case catgut had been used. They knew the source of the catgut and the probability of its being infected, which made the conclusion of its responsibility all the more probable. The extreme virulence of the cases seemed to be at variance with the results of the bacteriological examination. The conditions inside the body were not such as would be expected to favour the growth of the bacillus; in two of the cases there was no suppuration, and therefore no septic organism to prepare the way for the bacillus, and the tissues were well supplied with oxygen, which was also unfavourable to the bacillus.

Mr. Gunn, in reply, said Dr. Richardson had made extensive inquiries as to the methods of sterilisation employed, and had then come to the conclusion that there was no absolutely perfect method.

# WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD JUNE 4TH, 1909.

Mr. Canny Ryall, in opening a discussion on SPINAL ANALGESIA, showed a series of diagrams illustrating the technique

showed a series of diagrams illustrating the technique which he employs at the present day. He now operates on all parts of the body under the influence of this method, and has injected patients who have

had such operations as craniectomies, excision of the sympathetic, extirpation of the larynx, and excision of one half of the tongue, together with removal of the glands from both sides of the neck, performed painlessly and without danger. Children are not exempt, for he has injected a little girl, two and a half years of age, who was submitted to an operation on the head without the slightest alteration in her general condition. He introduced the method of making high injections into Budapest and Vienna. In Vienna he injected an old woman from whom Professor Eiselberg removed the greater part of her thyroid, weighing over 12 oz., with the greatest success. These results are due to Jonnesco's discovery which enabled him to incorporate strychnine with novocain. Novocain is a depressant to the vital centres. Strychnine, on the other hand, is a stimulant. When these drugs are mixed together and injected into the subarachnoid space, the strychnine, by neutralising the depressing effect of novocain, prevents the occurrence of respiratory paralysis. Having described numerous experi-ments which have been carried out, he mentioned that he had given a dog a suboccipital injection containing ao centigrammes of novocain, without death resulting. ao centigrammes of novocain, without death resulting. For operations on the upper part of the body the needle is inserted into the first, and for operations on the lower half, into either the eleventh or twelfth dorsal spaces. He rarely now uses lumbar puncture, for he obtains much better results by giving the injections into the dorsal region of the spinal canal. Although sub-occipital injections have been given by him, he finds no advantage in making a cervical him, he finds no advantage in making a cervical puncture, for perfect analgesia, lasting an hour or longer, can be obtained in the head and neck, by injecting the solution between the first and second dorsal spines. The great danger of spinal analgesia is the likelihood of respiratory paralysis supervening, but now that we know strychnine prevents its occurrence. it should be the duty of everyone employing this method to incorporate this drug with the analgesic solution. He cannot understand why spinal analgesia is not more often used in this country, for in a great number of cases it has many advantages over general anæsthesia.

## CORRESPONDENCE.

# FROM OUR SPECIAL CORRESPONDENTS ABROAD.

#### FRANCE,

Paris, June 13th, 1909.

DEPOPULATION OF FRANCE.

TUBERCULOSIS carries off annually 150,000 persons in France. This large mortality might be considerably reduced, affirms Prof. Courmont, by serious prophylactic measures as obtain in England and Germany.

The first step in this direction should be the destruction, as far as possible, of the seed by which the malady is disseminated. Phthisical patients expectorate millions of bacilli daily, and this emission goes on for years, commencing almost always before the patient takes to his bed. Many of these patients lead a normal social life, mixing with healthy persons, and spreading contagion around them. Here isolation is not possible, yet something should be done in view of self-preservation.

The examination of the sputa of all the patients, even the poorest, should be made, and for this purpose laboratories for the diagnosis of the affection should be created in every province. On the other hand, the habit of spitting on the ground or in public vehicles should be suppressed as much as possible, as it constitutes one of the great factors of dissemination. The use of cuspidors should be more general, whether in railway stations, public edifices, or in the sick room.

The precautions to be taken as regards the patients

The precautions to be taken as regards the patients themselves, although necessary, are difficult in their application.

Isolation was proposed, but neither the patient nor his friends would accept it. Notification of tuberculosis is not compulsory in France, contrary to what exists in other countries.

According to Prof. Courmont, it should be rendered obligatory as soon as bacilli are found in the sputa. Compulsory disinfection of the dwelling, of handker-chiefs, cuspidors, should follow the notification.

The question of isolation of the patients in separate wards, pavilions, or hospitals is of great moment. A ministerial circular of 1904 prescribed isolation, but in many hospitals the tuberculous patients are in the common wards, and thus constitute a danger to the other inmates.

Consumption hospitals as existing in England should be created in every region; these sanatoria should be open to patients in every stage of the disease, both curable and incurable.

Certain professions should be looked after and protected. Landouzy proved that washerwomen were particularly affected with tuberculous disease, and this professional malady would be diminished the day when tuberculosis being notified, the infected linen would no longer be mixed with the rest.

Bakers are also very liable to the malady; it is said that one-fourth of the bakers are consumptive! The assertion may be exaggerated, but it is certain that a great many of them fall victims to the disease, and the bread handled by these bakers, constantly coughing, is contaminated to the danger of the public. The only remedy here is the substitution of the mechanical to

the hand troughs.

In order that all these measures should be put into practice, the public mind should be educated by lectures, pamphlets, press articles, instruction in the

schools and the regiments.

The destruction of bacilli of animal origin is of paramount importance. Pork meat when tuberculous is highly dangerous, but in France at least, pork is rarely tuberculous.

Dogs, especially in towns, are more frequently tuber-culous than is believed and propagate the malady. The parrot is very contagious (tuberculosis of the

bill).

Bovine tuberculosis is very common; the meat is sometimes dangerous, the milk very frequently. Clinical diagnosis being almost impossible during a long period of the disease, prophylaxy should be based on the use of tuberculin. If the temperature rises notably within 24 hours after an injection of tuberculin (the old lymph of Koch), the probabilities are that the animal is infected, and should be immediately removed from the stable. removed from the stable.

A very severe control of the dairies should be rendered obligatory, and a law passed permitting an indemnity to the proprietors of the diseased animals. All this will take time, but in the meanwhile, the public should be warned against eating raw meat and drinking unboiled milk.

After considering the seed, a word about the soil is necessary for the conclusion of this study of the most

important question of the future of the race.

As we have seen, the human soil resists the invasion of tuberculosis fairly well, and to increase this chance of resistance several measures should be taken. If tuberculosis is not directly hereditary, the children of tuberculous parents are more or less predisposed to contract the disease; they should consequently be removed from the seat of contagion to the country. Alcoholism predisposes to the malady, and should be denounced urbi and orbi.

Tuberculosis being a malady of the weak, the insufficiently fed, and ill-housed, it should be regarded as a social evil and treated by social remedies.

One of the great producing causes of this malady is insalubrious dwellings, and against which little or nothing is done in France. In England, on the contrary, legislation concerning houses unfit for habitation is very efficient, and London has spent millions during the last thirty years on sanitary improvements in the poor districts of that immense city where tuber-culosis has in consequence notably diminished.

Germany arrives at the same result but by different means. It has created popular sanatoria thanks to its laws on compulsory insurance. By the law of 1883 insurance was rendered obligatory against sickness and accidents, and more recently (1891) against invalidity and old age. Every German workman earning less than £100 a year, is submitted to this obligation; em-

ployers and workmen contribute equally to the insurance fund.

After some years it was perceived that the expenses sickness, invalidity, old age), exceeded the receipts; it was the bankruptcy of compulsory insurance. Instead of resigning to the fatality, the Germans commenced a study of the whole question, with the hope of discovering the causes of the deficit. Tuberculosis was soon found to be the delinquent, and it was decided to take measures against it. Practical people as they are, they decided on creating popular sanatoria, where the workman is treated at the very outset of the disease. By uniting the two insurance funds (sickness and invalidity old-age) over 80 sanatoria were built throughout the country, containing 20,000 beds, with the result that two or three years afterwards, not only were all the building expenses paid, but the receipts exceeded the expenses. In 1902 the reserve fund exceeded twenty million pounds, enabling the administrators to lend two and a half millions for the construction of workmen's dwellings and over eight millions to agricultural industries.

In seven years, the simple fact of interesting them-selves in the struggle against tuberculosis, the German insurance agencies have economised millions of pounds, and this gain represents many human lives. When the workman is ordered to the sanatorium, his

wife and children are supported by the insurance fund.
In France, says M. Courmont, the workman suffering from the disease, works up to his last breath or until he is obliged to go into the hospital and his family is reduced to misery. Without obligatory insurance no prophylaxy of tuberculosis is possible.

# GERMANY. Berlin, June 13th, 1909.

At the last meeting of the Medical Society, Hr. Edwin Pfister gave a demonstration of BILHARZIA DISEASE.

The bilharzia, he said, was a bi-sexual distoma, the exact mode of whose infection of the human system was hitherto uncertain. The males were more powerful than the females, and bore at the extremity a ductus gynæcophorus which wrapped round the female

like a mantle. Hr. Goebel (Breslau) said that the eggs settled in the veins of the pelvis, and were specially numerous in the walls of the bladder and rectum; it was the eggs and not the adult worms that were pathogenous. By means of their spurs they forced their way into the walls of the capillaries, then through them, and were continually pushed forward into the tissues by were continually pushed forward into the tissues by other eggs behind them, so that at last they were capable of filling the bladder walls with infarcts, and becoming calcified. When they were forced into the epithelium they set up a growth, polypi developed, having a hollow space in the centre, and so a cystilize cystica resulted. Even if true new growths were rare, carcinomata certainly developed, which, in the speaker's opinion, were so far in etiological connection with the parasite that the eggs, acting as foreign bodies, set up an atypical growth in the epithelical state of the state thelium. It also happened in rare cases that both ureters and kidneys became diseased; they might block up the ureter and so lead to hydronephrosis; carcinoma of the kidney had also been observed.

Diseases of the intestine and peritoneum were also brought about by the parasite; in the one situation, polypus formation; in the other, pseudo-tuberculosis. The speaker had also seen elephantiasis of the scrotum and perinæum caused by bilharzia, and calculi in which the worms were found. A large number of preparations and projection illustrations

were shown.

Hr. Orth gave an account of a parasite met with and studied in Japan, the schistosomum japonicum. It belonged to the same group as the bilharzia, but it was larger than that one, whilst the eggs were smaller, and carried no spur. These worms also lived in the region of the branches of the portal vein, but passed less frequently into the pelvis, but laid their eggs in the liver, lungs, walls of the intestines, and brain. Giant cells developed round the eggs. The parasite occurred in China and Japan.

Hr. v. Hansemann remarked that the bilharzia was an especial sponger on the epithelium. Although car-cinoma might arise where it settled, it could not be looked upon as a carcinoma parasite in the strict sense of the word.

ÆTIOLOGY OF HYPERTROPHY OF THE PROSTATE. This subject was brought forward by Hr. Rothschild. In a large series of cases in which there was a possible commencement of hypertrophy of the prostate he had made investigations and had drawings made of the parts. The origin of the changes, he claimed, was in periglandular infiltration around the outlet openings, through which these were blocked up; this resulted in retention in larger or smaller sections of the prostate, whereby a compensatory hypertrophy was set up in other parts.

As regarded treatment, a deduction might be drawn

from these facts that the so-called sexual operations, on which for a time such great hopes were centred, as well as the proposed ligature of vessels, were without any object or aim. He thought an intermittent treatment of the chronic prostatitis was rather indicated, in order, if possible, to prevent the formation of cicatrices or masses of connective tissue in the

prostate.

# AUSTRIA. Vienna, June 13th, 1909.

INFANTILE SPINAL PROGRESSIVE ATROPHY. AT the Gesellschaft für Innere Medizin, Popper presented two sisters, æt. 4 and 2 respectively, who seemed to be suffering from the Hoffmann-Werdnig disease, viz., progressive muscular atrophy in the young. According to the mother's story the children were healthy and active when they were born; no apparent weakness about legs or arms. About six months after birth the movements of the legs and arms began to get gradually weaker, commencing in the legs. Through length of time it extended over the legs. Through length of time it extended over the entire body, the limbs becoming quite helpless, and the child being unable to sit up without support. At first, never having learned to walk, the legs remained thick, but soon became emaciated. Their present contains the state of the state o dition may be recorded thus: The elder fairly well nourished for its age, the cranium normal, the brain and cerebral nerves in the same condition. The younger, two years old, was soft and flabby with apparent fatty degeneration of the cellular tissue, so that the muscles of the extremities, which were certainly atrophied, could scarcely be felt. In consequence of the weakness the child could scarcely raise its hand to its mouth. The left arm at the shoulder-joint was quite loose, and could be bent far beyond the normal range; there were no contractions or fibrillary vibratowards the spine, the thorax crushed together and the head had to be held up. The muscles of the shoulders, back and pelvis were distinctly atrophied, while the lower extremities were in the same condition. There was no hypertrophy present, and both feet assumed the equino-varus position. There was no tendon reflex, and degenerative reaction was obtained by the electric current. The sphincters were normal, sensibility undisturbed, and the intelligence active. The elder, a girl, æt. 4, had a similar condition, but from the history it appeared to be more protracted in its approach than in the younger. There were still slight contractions to be obtained in the lower extre-

mities, which were held in the bent position.

These symptoms seemed to agree in every particular with Hoffmann and Werdnig's recorded cases under "Chronic spinal muscular atrophy having a con-genital basis," or what they preferred later to designate "Premature infantile progressive spinal muscular atrophy."

TOXIC COBRA HÆMOLYSIS.

Bauer and Lehndorff gave an account of their experiments with the toxine of the cobra. It may be remembered that Calmette gave the reaction with this toxine as characteristic of the early stage of tuberculosis when no fever or cachexia was present. Their experiments extended over 140 cases, with the serum in both healthy and diseased patients, and are now convinced that the toxine has no specific reaction for tuberculosis, as they only found it present in 47.3 per

cent. On the other hand, they found it more intense in febrile and cachectic phthisis than in the early nonfebrile state. In syphilis, however, they had 50 per cent. of positive results. In the new-born the cobra toxine was absent in the serum, although present in the retro-placental blood of the mother. In cerebrospinal effusions and many other sera, it seemed to have an active antagonistic action. Frankl thought that the maternal serum may account for this differ-ence, as it possesses a large quantity of lecithin, while the child has none, and it has long been recognised that the placenta is richer in lecithin than any other organ of the body. Landsteiner and Halban, only a organ of the body. Landsteiner and manual, only a year ago, proved this difference of serum in mother and child, which is certainly of great serological importance when discussing toxines of this nature. There is another barrier to the similarity in the two hæmatic systems, viz., they contain different lipoid constituents in the circulation.

### HUNGARY.

Budapest, June 12th. 1909.

AT the recent meeting of the Budapest Inter-Hospital Association, Dr. Révész read a paper on HOT SALT SOLUTION FOR ULCERS.

He extols hot physiologic salt solution over all anti-septics. He said these, if strong enough to be bactericidal, must necessarily cause death of tissues already lowered in vitality. The salt solution (9-1,000) used at a temperature of 50° C., has a physiological effect on the tissues promoting phagocytosis, and at the temperature employed is fatal to some bacteria, though not to spores. The ulcer is irrigated with the solution for a quarter of an hour, and a sterilised dressing (gauze, cotton wool, and bandage) is then applied. This is done daily until the ulcer cleans, then as often as necessary. Healing proceeds rapidly, and the method is especially suitable for cases which cannot afford time to lie in bed.

Dr. Sas read a paper on the Permeability of the Intestinal Walls. He said that many experiments on new-born guineapigs have convinced him that the intestinal walls are not permeable by bacteria, with the sole exception of tubercle bacilli. Even if small amounts of the latter are added but once to the food, a tuberculosis will develop, just like in older animals. The infection generally takes place from the mouth and the verminance of the control of the contr form appendix. The bacilli will travel through the walls without causing any loss of continuity, and eventually reach the lymphatic system. On inoculating other animals with the blood and lymphnodes of these guinea-pigs, non-tuberculous nodules developed, which may be an evidence of immunisation. Foreign proteids were not absorbed by the intestinal walls, yet slight amounts of diphtheria and tetanus antitoxin passed through in young, but not in older animals. In rabbits the intestinal walls were found much more permeable towards both bacteria and proteids.

THE INFLUENCE OF X-RAYS ON THE BLOOD. The X-rays seem to have a specific action upon the blood, for the leucocytes rapidly disappear after exposure, says Nemes, in the Orvasok Lapja for May 20th. In small animals, such as mice, the blood may be found completely free after an exposure of several hours, while with larger animals it is much more difficult to destroy all the cells. The destruction goes on chiefly in the circulating blood itself, for at certain Among the different varieties of white cells, the lymphocytes seem to possess the least resistance. Owing to the breaking down of the white cells, a leucotoxin is formed in the serum both within and without the body. It is an interesting fact that if this leucotoxin is injected into other animals, a decrease of the number of leucocytes may be seen soon after. leucotoxin may be rendered inactive by heating up to \$5° to \$60° C., it passes from the mother to the fœtus by way of the placenta, and it will eventually produce an immunity against itself. The cause of death after exposure is only rarely to be ascribed to infection resulting from dermatitis; in the majority of cases an intense nephritis must be held responsible. The hæmoglobin, red blood cells, and the blood platelets

are only slightly affected by the Röntgen rays. Two Germans, Linser and Helber, have carried on similar experiments with radium and with ultra-violet light, but an effect upon the blood was never detected. It seems that these rays do not possess the power to penetrate the tissues to the same extent as the Röntgen rays.

Pernicious Vomiting.

At the Medical Society, Dr. Sebestyéa said that for the milder cases of pernicious vomiting the usual remedies must be tried. The intestinal tract should be thoroughly cleansed, and large injections of water may be given, and the stomach washed out. If the vomiting persists, however, it takes on the pernicious form, and then the only thing that will end it is the determination of the pregnancy. For this the rapid dilatation of the cervix and the emptying of the uterus has been the most advised means, but there are beginning to be doubts about its applicability in some of the severest cases where the symptoms have affected the general health very much. The shock of the operation may of itself kill the patient. The administration of an anæsthetic adds to the danger, and if chloroform is given the toxic process within the body seems to be intensified. All the portions of the fœtus and its adnexa must be removed, or the vomiting will continue. He referred to a case of Dr. Stone's, of New York, in which a small portion of placenta was left, with failure to relieve symptoms. When this was removed the vomiting stopped.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

MEDICAL INSPECTION OF SCHOOL CHILDREN IN MIDLOTHIAN.—The Education Committee have made a series of recommendations on this subject, briefly as follows:—The inspection of school children is to be placed under the general direction of the county medical officer of health, with the assistance of such other specially appointed medical officers as may be required. The duties of the chief medical officer are to consist of direction and organisation of the work of his subordinates, transmission of all reports on sanitation or infectious disease reaching him to the public health officer; the duties of the junior medical officers are to report on sanitation of school premises, on infectious disease, and on the results of their inspection of school children. They are also to urge parents to procure medical advice for their children when this seems required, and to report failure to comply to the School Board concerned. They may be required to report to the Board on cases in which illness is alleged as an excuse for irregular school attendance.

EDINBURGH ROYAL INFIRMARY.—The medical outpatient department, which has long been in a very unsatisfactory condition as regards its premises, has been remodelled during the past year. There has now been provided a large waiting-room, with proper isolation rooms for suspected cases of infection, and with dressing rooms and lavatory accommodation. These dressing rooms communicate with a large demonstration room with raised benches, to accommodate eighty students, for whom a separate entrance is provided. Private rooms for the physicians on duty, and a dark room for the examination of the eye have also been provided, and the department is so planned that patients leave the building by a special exit, without returning through the waiting-room. In passing it may be remarked that in the Royal Infirmary it has never been the practice to supply medicine, but only to give advice, to out-patients. The whole department is on thoroughly modern lines; there is special accommodation for the nursing staff, and all the fittings and furnishings are thoroughly up-to-date. The cost of the department has been about £3,000;

The Cost of the department has been about 25,000, the architect is Mr. A. Balfour Paul.

The Budget and Alcoholic Drugs.—At the meeting of the directors of the Edinburgh Royal Infirmary on the 31st ult. the adverse effect of the

new spirit duties on the finances of the Infirmary was considered. Dr. Mackenzie Johnstone submitted a statement based on last year's figures, showing that the increased cost of alcohol would affect the institution to the extent of £112. This does not apply to alcohol as a beverage, but to the preparations in which alcohol is largely used; anæsthetics alone mean an increase of nearly £50. A letter was read from Dundee Infirmary asking support to get some concession in regard to the making of tincture and other pharmaceutical preparations. The result of the tax is really an increased expenditure on drugs amounting to nearly 10 per cent.

ROYAL COLLEGE OF PHYSICIANS' LABORATORY.—
The Laboratory Committee has recently issued new regulations concerning the reporting on specimens. Hitherto such reports have been issued gratuitously to all and sundry medical men, and a good many years ago the City paid the Laboratory several hundreds annually for its reporting work. When the Usher Institute was opened the City reporting work was transferred to it, but a great many practitioners continued to send their specimens to the College Laboratory, which in its turn, went on giving gratuitous reports. The reporting, however, had to be kept in check in some way or another, and in the future a scale of charges, not differing materially from those in vogue elsewhere, will be made to practitioners who are not Fellows or Members of the Royal College.

REGISTRATION OF NURSES IN SCOTLAND.—The

following resolution has been forwarded to the Prime Minister:-The Executive Committee of the Association for the Registration of Nurses in Scotland, at a meeting held in Edinburgh on May 14th, expressed their satisfaction that the Prime Minister was unable to assent to the proposals of the deputation which waited on him on the 13th inst. This Association (which represents public opinion and, with a few exceptions, the opinions of the medical and nursing profession in Scotland) trusts that it will be afforded an opportunity of placing its views before any committee of the House of Commons that may be appointed to deal with that important subject. The statement (already published in the Medical Press) gives in detail the reasons of the Association for objecting to Registration Bills No. 1 and No. 2, and although Scotland does not desire to be associated with the scheme of either of these Bills, the Scottish committee see no reason why a Bill should not be introduced which would be satisfactory to England, Scotland and Ireland, arranging for Representation Branch Councils, and for a separate register for each country. to be embodied in one common register, the branch councils to supervise examinations in their own country, just as is done under the Medical Act (1858) and its subsequent amending Acts. The views held by this Association coincide generally with the recommendations of the Select Committee which reported to Parliament in 1905 on the question of the State Registration of Nurses.

#### BELFAST.

"Interesting Meetings" in County Down.—Much interest has been aroused in medical circles by a series of meetings held this week in the northern parts of County Down, all of them addressed by Dr. Henry O'Neill. The daily papers, evidently rather at a loss how to ticket them, put them under the heading of "Interesting Meetings." They are supposed to be in furtherance of a plan to obtain more labourers' cottages, but many other questions are discussed, and though party politics do not seem to be alluded to, there is an idea abroad that these meetings are stepping-stones on the road to Westminster, towards which that original and energetic surgeon set his face when a few years ago he qualified as a barrister. In Portaferry, for instance, Dr. O'Neill dealt not only with the question of labourers' cottages, but also with the need for better quay accommodation, the need for more lighthouses on the coast, the necessity for a technical school, and the medical inspection

of school children. On the last subject he made the rather startling remark that Ireland was the only country in Europe where school children received no periodical medical supervision

country in Europe where school children received no periodical medical supervision.

Belfast Board of Guardians.—At the annual meeting of the Belfast Board of Guardians, held last week, Dr. J. S. Bryars was unanimously re-elected chairman. During the past year, his first in office, he has won the respect of all parties by his fairness and courtesy in dealing with a sometimes unruly board, and his re-election is a very real compliment.

Expenses of the Belfast Health Commission.—

EXPENSES OF THE BELFAST HEALTH COMMISSION.—An interesting discussion took place at a special meeting of the Corporation last week, when the question of the payment of the Corporation's share of the expenses of the late Belfast Health Commission came up for settlement. It appears that counsel's opinion had been taken, and was to the effect that they were not liable for the expense of the three English members of the Commission, and many members of the Corporation wished to refuse payment. The Earl of Shaftesbury, in a most sensible speech, moved that the payment should be made, sooner than litigation started which might land them in far heavier expenses, and specially as they admitted that they had got good value for the money. After a lively discussion the motion was carried by 17 votes to 9.

Tuberculosis in County Down.—At the annual

TUBERCULOSIS IN COUNTY DOWN.—At the annual meeting of the Down County Council, held last week, the chairman, the Rt. Hon. Thomas Andrews, referred at length to the question of tuberculosis. The county had, he said, made great progress in many directions, such as the provision of labourers' dwellings, technical schools, workhouse and asylum accommodation, etc., but one great blot remained on it, and that was the presence of tuberculosis, over 5,000 cases in the country causing 500 deaths each year. He had no cut-and-dry scheme to bring before them, but he wished them to turn their minds to this great problem.

### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

#### THE PRESS AND THE EMPIRE.

To the Editor of The Medical Press and Circular. Sir,—Before me is one of the leading papers of the day; I need not say whether Lendon or provincial. It contains a report of the second sitting of the Press Conference, the subject for discussion being "The Press and the Empire." Many noble sentiments, and aspirations by distinguished statesmen, with much laudation of that noble institution the Press of the Empire, are reported. Occupying nearly a full page opposite the report there is printed, as an editorial article, a fulsome puff of a grotesque system of quackery. This puff may have cost any sum between £100 and £250. In other parts of the same paper are other quack advertisements representing at least another £200. At a very mederate estimate the annual income of this great organ, from a traffic which is not only fraudulent, but cruel and deadly, must amount to not less than £30,000. This same paper gives place on occasion to a great variety of financial advertisements which to the eye of an astute City editor display the word fraud in large letters across their face. It is possible the proprietors are quite ignorant of the nature of the enterprises they are thus abetting. Some papers reject advertisements of the kind I refer to; some admit them innocently, and some perhaps in putting them in can be charged with nothing worse than carelessness; but there can be no doubt that the papers, nearly all of which now augment their income from these foul sources, are in most cases well aware of what they are doing. Medical quackery of the coarsely fraudulent kind, especially the traffic in nostrums and sham apparatus, has been more than sufficiently exposed during late years in the medical papers alone, and in a fashion which makes it impossible for any well informed newspaper proprietor to affect ignorance of its

character. The Australian Royal Commission has again done enough to provide enlightenment, whilst cases in the law courts of every grade have further furnished more than sufficient evidence during many years. Leading articles in the foremost papers of the day taking part in this exposure were formerly common: and, strange as it seems, quite lately editorials of this kind have appeared denouncing various forms of quackery, whilst fraudulent advertisements of every kind have been appearing in the same pages. It seems desirable to free one's mind from cant in considering the trade of journalism. If many newspaper proprietors are capable for a consideration of deliberately betraying the simple and suffering public into the hands of cynical knavery there seems no depth of degradation to which under similar temptation they may not be capable of sinking. Why should they not for pay enrol themselves in the ranks of the reptile press subsidised by a foreign statesman, and take part in betraying their country into the hands of its enemies. Baseness equal to this was charged against a great section of the United States Press by ex-President Roosevelt in a speech a few months ago; and the morals of entirely unscrupulous money-grubbers in this country are not likely to be superior to those of their brethren across the Atlantic.

1 am, Sir, yours truly, HENRY SEWILL.

The Old Rosery, Redhill, June 9th, 1909.

#### "THE CHURCH AND HEALING."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your comments on above subject in last issue are much to the point, "A certain section of the Church is being drawn towards Christian Science, falsely so-called." The wonderful "cures"(?) said to be effected by this agency we must charitably suppose are explained by "terminological inexactitudes," or the neurotic element in the person acted upon. The new treatment by prayer and poultice (simultaneously applied, we presume) should soon produce astounding effects, the difficulty being which treatment to attribute the "cure" to. Will payment be made by results? As the Christian Scientists, from their apostle, Mrs. Eddy, downwards, manage to make it pay, so different from the advice given by the Master (Matthew x., 8, 9, 10): "Heal the sick—freely ye have received, freely give." Mrs. Eddy, at any rate, has made a good thing out of Christian Science, while posing as a second "Eddy" stone lighthouse, with her "Edifying" handbook, "A Key to the Scriptures," supposed to throw light on the Sacred Volume.

I am, Sir, yours truly,
ALEXANDER DUKE.

London, W., June 10th, 1909.

AN URGENT APPEAL FOR ASSISTANCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—May I ask you courteously to publish a further list of donations in answer to the "appeal" which you kindly inserted in THE MEDICAL PRESS AND CIRCULAR for May 19th, 1909?

I am, Sir, yours truly,			
John W.	M	001	RE.
•	£	s.	d.
Amount already acknowledged	22	19	0
Dr. A. J. Horne, President, R.C.P.I	3	.3	0
Mr. Lentaigne, President, R.C.S.I	3	3	0
Dr. Lombe Atthill (Monkstown, Co.			
Dublin)	2	O	O
"Melitensis" (Malta Postal Orders)	2	0	()
J. J. Charles, Esq., M.D., Portstewart,			
Co. Derry	1	0	o
"Sympathy"	2	2	•
"A Practitioner" (Dublin)	1	I	0
Dr. Arthur Finegan (Mullingar)	1	1	0
Dr. J. Knox Denham (Dublin)		1	О
Total	30	10	_

June 8th, 1909.

### OBITUARY.

#### WILLIAM HAMPDEN BRODIE, M.D.ABERD.

We regret to announce that the death has occurred, near Johannesburg, of Dr. William Hampden Brodie, a medical practitioner well-known on the Rand, where he was highly esteemed. Dr. Brodie graduated at Aberdeen University in 1880. He afterwards visited America, and subsequently proceeding to Johannesburg in the early days, he took an active part in the work of the Reform Committee, holding as he did strong sympathies with that movement. He served during the South African war as Medical Officer on the hospital ship, Lismore Castle, and No. 6 General Hospital, Johannesburg. He had also been Medical Officer of the W.N.L.A., and of the Ferreira Group of mines, and till recently had been acting as Medical Adviser to the Central Administration. The cause of death was pneumonia, with which Dr. Brodie was struck down only a few days before his death.

HENRY JOHN HUNT, M.R.C.S., L.R.C.P., J.P.

WE regret to announce that Henry John Hunt, a well-known Harrogate medical practitioner, has died in London at the age of sixty-eight. He was a member of the Royal College of Surgeons, and a Licentiate of the Royal College of Physicians, and had held the appointment of Surgeon to the Harrogate Bath Hospital. Mr. Hunt was a magistrate for the West Riding of Yorkshire.

HENRY KAY RAMSDEN, M.B., CH.B.VICT. WE regret to announce that Dr. Henry Kay Ramsden, of Chelsea, has died after a long illness at the age of forty-two. He took the M.B., Ch.B. degrees at Victoria University in 1891, and held various appointments, including those of House Surgeon at the Central London Throat, Nose, and Ear Hospital, Clinical Assistant at the Royal London Ophthalmic Hospital and Central London Ophthalmic Hospital, and Surgeon to the Town Hospital, Guernsey and the General Hospital, Chillagoe, Queensland. He had also been a civil surgeon with the South African Field Force, and was a Surgeon Captain in the 6th London Riffes.

# MILITARY & NAVAL MEDICAL NOTES.

It is notified by the War Office that a new regimental march has been approved for the Royal Army Medical Corps. The writer recollects well the time when a band was absolutely refused by the authorities for the Corps when permission was asked to organise it. But that was a time of deep jealousies and antiquated views of the "stay-where-you-are" school! The minds of men in power now have expanded; they move with the times, and adapt themselves to environment.

An American Army medical officer representing the United States, who was studying our system at Aldershot, expressed the view to the writer that the R.A.M.C. should have colours. That may come later. But, festina lente.

THE Government of Mysore (India) have recorded their appreciation of the ability with which Lieut.-Col. J. Smyth, Indian Medical Service, has discharged the duties entrusted to him during his deputation to study the system of sanitation in Japan. Government observes that most of the methods adopted in Japan are purely European, and inapplicable to Indian conditions. Government have decided on granting an extension of Lieut.-Col. Smyth's service in Mysore for five years, and negotiations are passing between the Mysore and Indian Governments on this proposal.

An order has been received at the dockyards that, in view of the attendant risk to health, no virus or poison should be used in future for the extermination of rats without the prior concurrence of the responsible Medical Officer of the Dockyard.

THE position of the Royal Naval Volunteer Reserve is alluded to by a correspondent of the Times (June 41, who says of the medical officers that there are at present 30 thoroughly qualified surgeons. They form a small but a valuable reserve for the Navy. They are enabled to acquire experience in work of a specially Naval character by being attached for short courses of instruction in a Naval hospital and on H.M.'s ships, receiving at such time the pay of their rank. If they are certified by the Medical Director-General of the Navy as having taken full advantage of the instruction, extra capitation grants are allowed for them. It is greatly to be hoped that this most useful branch of the Reserve may be increased numerically.

In a health point of view the relative values of coffee and tea for soldiers is worthy of attention. Dr. Huchard, of the Necker Hospital, and a member of the Paris Academy of Medicine, considers that the decision to replace coffee by tea in the German Army will be a good thing—for the enemies of Germany. He thinks that the experiment, besides being a waste of money (since the authorities will be obliged to return to coffee—why, he does not say) will have serious consequences for the health of the soldiers. He says that either the soldiers will be given only a small quantity of tea, in which case they will derive no nourishment, or they will be given a lot of tea. and with it cardiac trouble.

THE insanitary state of quarters for married soldiers owing to overcrowding is receiving much publicity, and it is to be feared that, in consequence, much harm accrues to the Army. There can be no doubt that many of these quarters would not be passed as fit for residence under the inspection of officers of health in civil life. No fault whatever for this lies with the Army Medical Service, who are absolutely disheartened at their repeated reports and recommendations bend pigeon-holed and being met by the authorities with a non possumus and "We have no money—."

The Leeds Army Medical Corps—i.e., the 1st and 2nd West Riding Field Ambulances R.A.M.C., are spending some time under canvas at Alwoodley, a stretch of country outside Leeds. They are over 250 strong, and marched out with full medical accountement, operation tent etc. There were 40 horses and three ambulances. The Military Mail says:—The corps presented a smart and soldierly appearance as they passed through the city under the command of Lieut.-Col. A. E. L. Wear." Attached to the unit is a transport company and the 2nd Northern General Hospital Staff of the R.A.M.C. School of Instruction.

DR. SEYMOUR STRITCH, Governor of the Apothecaries' Hall, Dublin, has been presented by the directors of the Apothecaries' Hall with a piece of plate on the occasion of his marriage.

#### The Harben Lectures for 1909.

THESE lectures will be delivered by Prof. R. Pfeiffer. M.D., Breslau, in the Lecture Room of the Royal Institute, on Monday, June 21st, Wednesday, June 23rd, and Friday, June 25th, at 6 p.m.

## The Cavendish Lecture for 1969.

SIR VICTOR HORSLEY, F.R.S., will deliver the Cavendish Lecture before the West London Medico-Chirurgical Society on Friday, June 25th, at 8 p.m. in the Kensington Town Hall. Subject, "The Cerebellum."

# REVIEWS OF BOOKS.

# AIDS TO FORENSIC MEDICINE AND TOXICOLOGY. (a)

APART from the desirability of calling attention to a new edition, a review of this book is almost super-fluous. When six editions have been voraciously devoured by students, a book may truly be considered acceptable. The reasons for its popularity may be many, but probably the chief is the way in which the subject-matter is treated. A student with an already surfeited mind will turn with relief to a book where information is presented in a manner reminiscent of the "Comic Blackstone." The author is a humorist, but he also appreciates the delicacy of certain portions of his subjects. His knowledge of human nature is great, and, with a keen savoir faire of his subject, makes the book both eminently readable and useful.

A great deal of new material has been added, especially in Part I. ("Forensic Medicine"), and abstracts of most of the new Acts bearing on the subject are given. In the toxicological part we notice the inclusion of synthetical coal-tar products such as the analgesics so popularly used and abused. We may note that the author does a little injustice to the tests for lead in water when he says that one-tenth of a grain of lead per gallon can be detected. It is sometimes necessary to detect and estimate a fifth of this quantity.

# PATHOLOGY AND TREATMENT OF DIABETES. (b)

In these three lectures Dr. Pavy gives a lucid exposition of his ideas concerning the ætiology of diabetes. He begins by attacking in no uncertain way the most He begins by attacking in no uncertain way the most generally accepted among the old views of carbo-hydrate metabolism, known as the "glycogenic theory." He points out that, as part of this theory, it was considered that sugar travelled free in the blood from the intestine to the liver, and that the liver was loaded with sugar. The blood in the henatic vains was bewith sugar. The blood in the hepatic veins was believed to contain more sugar than that in the portal system, and the systemic veins were said to be poorer in sugar than the arteries. All this had now been disproved. Sugar is normally present in the urine, in quantities too small to be detected by Fehling's solution, but proportional in amount to that in the blood. This contention could be proved by intravenous injection of sugar when it immediately appeared in the urine. On the other hand, ingestion of large quantities of experience in health median of large quantities of carbohydrate in health made no difference to the amount of sugar in the urine, so that it was inconceivable that it had obtained entrance to the blood in the form of sugar. The view that the liver was a powerful means of preventing sugar absorbed from the intestine from gaining access to the general circulation was disproved by Eck's fistula operation, for by this the liver was cut out of the

circulation, yet no glycosuria resulted.

Everything, he thinks, points to the disappearance of sugar at the seat of absorption, and for this he has a very ingenious explanation. After referring to the recent work, which has shown that carbohydrates may be transformed into proteid by the synthetic power inherently belonging to bioplasm, he points to the large number of lymphocytes in the absorbent area. These, he considers, furnish the active bioplasmic growth, which assimilates the sugar absorbed from the intestine, and carries it in the form of a large and complex protein molecule. It is thus locked up, and does not run off in the urine, as it assuredly would

do if it circulated as sugar. According to the author, the next step is one of autolysis of the lymphocytes, and in this process of melting down the protein that has been generated within them passes into a state of solution under the form of the albumin, globulin, and fibrinogen appertaining to the plasma. This is utilised by the tissues through the agency of a fermentlike material out of the body fluid. Looked at in this way, the tissues draw their nutrient supply from the material elaborated from the digestive products at the seat of absorption, instead of the digestive products being conveyed as such through the circulating system to the tissues.

To the liver he ascribes the function of storing the excess of carbohydrate in the form of glycogen. believes that with exercise a demand for sugar arises, which exhausts that in the blood, and so more is caught on from the liver. To supply this the glycogen is converted by enzyme action into sugar, which is combined with a protein molecule in the blood. He adduces evidence to favour the view that the pancreas acts by supplying a body which, in the language of immunity, performs the part of an amboceptor to link up the carbohydrate to the bioplasmic molecule, i.e., to the lymphocyte at the seat of absorption, and suggests that it may act similarly in the transformation of sugar to glycogen in the liver.

Dr. Pavy's position as an authority on diabetes is so great, and justly so, that these lectures could scarcely fail to be food for much thought, and may be said to constitute the last word on the subject. If one ventured a criticism, it would be that the theory he advances is of itself so complex and intangible, voking, as it does, the aid of various hypothetical enzymes, that, although eminently reasonable, it is at present beyond proof or disproof.

#### THE BONE MARROW. (a)

This handsome volume represents the results of Dr. Dickson's work during his tenure of the Crichton Research Scholarship in the University of Edinburgh, to which University it was afterwards submitted as a theses for the M.D. degree. The scope of the volume is sufficiently indicated by the title; it is in the main a description of the cells met with in the marrow in health and discourse and activation. health and disease, and a study of some of the reactions of that tissue. It is thus a really valuable introductory treatise, which will serve as a basis for further work, and will prove of great assistance to all engaged in the study of this most difficult structure. Dr. Dickson is less concerned with attempts to throw light on the causes of the phenomena he describeson the nature of chemiotaxis, for example—than with a description of the changes themselves. One of the chief problems in the cytology of the blood is the relationship of the various forms of leucocyte. The view adopted in the text is one now very generally held, viz., that the large non-granular basophile mononuclear is the source of the whole neutrophile series, and that it is itself probably derived from a smaller cell of similar character—the "undifferentiated lymphoid cell" (Wolff). The eosinophile and basophile series The eosinophile and basophile series are regarded by Dr. Dickson as totally distinct from the neutrophile series, and no definite opinion is expressed as to their origin. In discussing another vexed question, namely, the manner in which ervthroblasts lose their nuclei, Dr. Dickson leans to the view that the process is not one of extension, but of karyorrhexis or karyolysis. One of the principal features of the book is the wealth and beauty of the illustrations. The plates, particularly those showing the naked eye appearances of the marrow in health and disease, are alone sufficient to ensure its having permanent value. Although Dr. Dickson has not in this thesis made any revolutionary observations, his is a painstaking piece of work which will form a secure foundation for further research, and is a large mass of solid information on a very difficult subject.

<sup>(</sup>a) "Aids to Forensio Medicine and Toxicology." By Wm. Murrell, M.D., F.R.C.P., Physician to, and Lecturer on Clinical Medicine in, the Westminster Hospital, Joint Lecturer on Medicine in Westminster Hospital Medical School. Seventh Edition. Pp. 133. Sixteenth Thousand. London: Bailliere, Tindall and Cox. 1903. Price 2s. 6d. net.

(b) "Three Lectures on the Pathology and Treatment of Diabetes Mellitus, viewed from the Light of Present-Day Knowledge." By F. W. Pavy, M.D. LL.D., F.R.S. Reprint from the Lancel, Nov. 21st and 28th, and Dec. 12th, 1908.

<sup>(</sup>s) "The Bone Marrow: A Cytological Study." By W. E. Carnegie Dickson, M.D., B.So.Fd., F.R.C.P.Ed. London: Longmans, Green and Co. 1903.

ST. BARTHOLOMEW'S HOSPITAL REPORTS. (a)

THE new volume of the "St. Bartholomew's Hospital Reports " quite maintains the high reputation which the reports of this hospital have gained for themselves in past years, and reflects the greatest credit on its The volume before us contains some nineteen papers dealing with medical and surgical subjects, as well as the statistical tables dealing with the work of the hospital for the past year. Some of these papers are of guite unusual interest, such as that contributed by Dr. Herringham on "Gastric Ulcer and Gastro-Stasis." In this paper the author deals with the cases of gastric ulcer that have occurred in the hospital during the years 1887-1906. Dr. Cane gives an interesting analysis of 1,196 midwifery cases attended during the twelve months in the Extern Midwifery Department. In estimating the morbidity, Dr. Cane adopts the standard in use in Queen Charlotte's Hospital. By this standard every case is considered morbid in which the temperature rises above 100° F., whether the rise is accompanied or not by an increase in the pulse rate. According to this standard the percentage of morbidity among the 1,196 patients delivered was 14.3. The corresponding figures for Queen Charlotte's Hospital were 20.0 for 1,642 patients. We must congratulate Mr. Colt, the Senior Resident Anæthetist, on the much fuller report on anæsthetics which appears in this year's volume. In our notice of last year's reports we suggested this improvement, and we consider it a distinct addition to the volume for this year. We should have liked, however, a little fuller details of the fatal cases. The explanation of the third of these cases does not appear very clear from the information afforded us.

# ANATOMIE UND MECHANISMUS DER SKOLIOSE. (b)

This volume gives a very complete account of the anatomy of scoliosis. It is bound in an unusual method. The text occupies only a comparatively small bulk, the remainder being taken up by an atlas fitting in a separate pocket of the binding. This has the advantage of allowing the plates to be studied while reading the text without continually turning over the pages.

A good account is given of the alterations in shape and relations of the scollotic vertebræ, with their processes and ligaments, in the adult, and the same conditions are studied in the child. The changes found in other organs—liver, lungs, diaphragm, etc.—are accurately described. The chapters dealing with the minute structure of the bones and the mechanism of the scoliotic change are perhaps the most interesting. It is shown that on the concavity of the curve the bony lamellæ lie closer together, and are thicker than normal, those on the convexity being more open and delicate. The theories attributing this condition, on the one hand, to a mechanical compression and expansion directly due to the torsion, and, on the other, to a laying down and absorption of the lamellæ from the increased and diminished pressures on the opposite sides, are considered at some length.

The plates illustrate clearly and well the matter dealt with in the text. The book can be recommended to any who wish to study the anatomy of scoliosis in detail, and are conversant with the language in which

### PHYSICAL DIAGNOSIS. (c)

THE author has written a book which deals with the physical signs and diagnosis of diseases of the thoracic and abdominal organs. It is divided into seven sections. The first concerns general methods of examination, the second examination of the thorax,

(a) "St. Bartholomews Hospital Reports." Edited by H. Morley Fletcher, M.D., and W. McAdam Eccles, M.S., F.R.C.S. Vol. XLVI. Octavo. Pp. xviii, 287 and 190, 17 illustrations. London: Smith, Elder and Co. 1809.

(b) "Anatomic und Machanian."

the third and fourth examination of the bronchopulmonary system and mediastinum. Sections five and six are devoted to the examination of the cardio-vascular system and the physical signs of its diseases, and section seven to the abdomen. Its scope does not include diseases of the nervous or urinary systems, nor of the blood. As a record of the many physical signs which have been described, in association with abnormalities of the chest and abdomen, we think Dr. Da Costa's book may be said to be exhaustive, but it Da Costa's book may be said to be exhaustive, but it would have been advantageous to emphasise more forcibly those on which greatest reliance can be placed even at the risk of omitting the less important. But the feature which gives this work its greatest value is the author's scheme to correlate physical signs with clinical pathology. With this object in view, he first describes and explains the mechanism underlying the physical signs which may be obtained in the lying the physical signs, which may be obtained in the normal organ and then in the various morbid condi-tions of that organ. Each disease is then considered tions of that organ. Each disease is then considered separately. First, its morbid anatomy is described, then the physical signs which necessarily result, and finally the diagnosis. With so important a lesson to teach, it is a pity that the main issues are sometimes crowded out of their due position by minor points. The argument from pathological cause to physical effect is considerably helped by many good pictures of directly argument and other available illustrations. of diseased organs, and other excellent illustrations and diagrams are plentifully distributed through the book. We think, however, that the model studies do not seem in place in a scientific text-book.

#### GENERAL AND SPECIAL PATHOLOGY. (a)

It is with confidence and with a sense of pleasurable anticipation that one opens a book on pathology by two such distinguished exponents of the science as Drs. Dickson and Beattie, and in every respect is the confidence justified.

In these two volumes the authors have endeavoured

to supply an up-to-date knowledge of pathology, both general and special, which the advances of the last few years have rendered necessary. Great care has been bestowed in making the work full and ample, and the writings of the best authorities have been consulted and quoted whenever necessary, and the authors have succeeded in making their own views clear and distinct. The chapter dealing with the "cell" is one of the best we have ever read.

The illustrations are most excellent. After having read through the work most carefully we offer the joint authors our best thanks for their accurate scholarship, clear exposition, and literary taste.

### LITERARY NOTES.

Dr. METCHNIKOFF'S "Notes on Soured Milk and Other Methods of Administering Selected Lactic Germs in Intestinal Bacterio-Therapy," have been reprinted in pamphlet form of 20 pages by Messrs. John Bale and Co., Ltd. The author's remarks on curdled milk and the action of lactic fermentation in preventing butyric fermentation and putrefaction, and the con-sequent reduction of the sulpho-conjugate ethers in the urine is herein shown. As a means to this end the author suggests the advantage of introducing the living germs rather than lactic acid. He deals with the use of soured milk by races where longevity is common. and then with the virtues and shortcomings of Kephir and Yahourth. The author's opinion on this form of bacterio-therapy is summed up in the phrase: -1 hasten to repudiate the idea that these microbes possess the property of determining longevity or of averting old age, except in so far as they make for a high standard of health."

WOODHALL SPA is so well-known to the readers of this journal that further reference to its resources from a medical point of view would appear almost super-

(a) "A Test-Book of General and Special Pathology." By Dra. Martin Beattle and Carnegie Dickson. Pp. 556, 191 illustration, Rebman, Ltd.

Elder and Co. 1908.

(b) "Anatomie und Mechanismus der Skoliose." Von Woh. Dr. Carl Nicoladoni O.O., Professor der Chirurgie ander Universität Graz. K & Hofrat. Mit 54 Figuren auf 37 Tafelm und dem Portrat des Verfassers. Urban and Schwarzenberg, Wien, Berlin, N. Freidrichstrasse, 1865. Maximillianstrasse. 1909.

(c) "Principles and Practice of Physical Diagnosis." By John C. Da Costa, Jr., M.D. Philadelphis: W. B. Saunders Co.

fluous. A new handbook and guide to this "Salzo-Maggiore of England," however, is now before us, brought up-to-date, showing that many improvements have been made in the Spa baths, which have been considerably enlarged, and new rooms for the Aix and Vichy systems of douche massage built. Dr. Lionel Calthrop is still medical superintendent at the Spa, an assurance that patients sent there will receive scientific treatment.

# MEDICAL NEWS IN BRIEF

#### Medical Golf.

THE Ulster Medical Association has arranged to present to the British Medical Association a cup to the known as the "Belfast Cup," to be played for at annual meetings and to be won outright by any member winning it three times. It will be first played for on the Friday of the Belfast meeting, on the links of the County Down Club at Newcastle. The cup is designed after the well-known Ardagh Cup. It will be of silver and about nine inches high.

#### Case of Leprosy at Cardiff.

At the Cardiff Seaman's Hospital, on June 1st, one of the out-patients, a Chinaman, lodging in a seaman's boarding-house, was found to be suffering from leprosy. The man was at once admitted to the hospital, and completely isolated, and every precaution has been taken to prevent contagion. The Medical Superintendent is of opinion that the disease was originally contracted in China, prior to the departure of the patient from Hong-Kong two years ago, when he sailed for Europe on a British ship.

#### The Red Cross Society and the Territorial Scheme.

Mrs. C. Davies Gilbert, Vice-President of the District Branch of the British Red Cross Society, gave an "At Home" at Eastbourne, at which Sir Frederick Treves was present. Sir Frederick Treves, in explaining the aims of the society, said an extensive movement, which was not yet completely developed, was proposed for the Territorial Army. The War Office was about to issue within 10 or 14 days a memorandum of what they hoped the Red Cross Society would do in the Territorial scheme, and that under the idea—an idea we never would allow to enter our minds—that the country might be invaded. There were some who thought, however—and their opinion was worth heeding, too—that we might be in error in too strongly insisting on that fact.

#### Medical Golfing Society.

WE are asked to announce that the annual tournament of the Medical Golfing Society will be held at Burnham Beeches Golf Club on Thursday, June 24th. Play will be 18 holes match play v. Bogey under handicap. There will be three prizes in each division—handicap 12 and under, and handicap over 12. The "Henry Morris" Challenge Cup and the Medical Golfing Society's Gold Medal will be competed for. There will also be a Foursomes sweepstake in the afternoon. Any person on the Medical or Dental Registers can join on payment of the annual subscription (4s.), which includes entrance to the tournament. Entries, accompanied by subscription and giving lowest handicap, should be sent to Dr. L. Eliot Creasy, 36 Weymouth Street, London, W., on or before Monday, June 21st. Conveyances will meet trains at Burnham Beeches Station (G.W.R.). Cards may be handed in till 8.30 p.m.

## The Irish Medical Benevolent Fund Society.

The annual meeting of this Society was held during the past week. The President of the Royal College of Physicians occupied the chair. The report of the committee stated that the total amount of the grants recommended since the last distribution is  $\int 1.327$ . The total number of applications considered during the year was 90. Of these 81 were from the widows of medical men, 5 from, or on behalf of, their orphans, and 4 from medical men themselves. The number of appli-

cants this year has been very large, and the amount given in grants has strained the resources of the Society, yet to many of the recipients the aid given has fallen very far short of their claims, and of their urgent necessities. The amount received through the central treasurer was £226 3s. 6d., as compared with £195 the year before. The subscriptions received from branch treasurers amounted to £315 16s. 2d., as compared with £351 1rs. 3d. the year before. The Belfast and Co. Antrim Branch contributed £151 5s., including £5 5s. received too late for audit the previous year. Since the accounts were closed a further sum of £9 13s. 6d. had been received from county branches, £136 16s. 2d. received from county branches, £138 18s. 2d. should have appeared in last year's account, but was not received until that account had been closed. The branch treasurers doubtless do what they can to send their collections in time for audit. At present it is impossible to present the accounts in such a form as to make it easy to compare one financial year with another.

The President of the Royal College of Surgeons moved, and Dr. Cosgrave seconded, the adoption of the report. The former said that out of some 3,000 members of the profession in Ireland there were only 500 contributors to the fund. There was a falling-off in subscriptions, and he thought that one reason for this was that medical men did not know of the existence of the Society and of the work it was doing.

Amongst the other speakers were Dr. Hastings Tweedy, Sir Lambert Ormsby, Dr. J. Magee Finny, Dr. Garland, Dr. Knox Denham, and the Chairman, who pleaded for liberal support of the Society.

# International Congress of Nurses and Nursing Exhibition.

Just ten years ago there was founded in London the International Council of Nurses, which sought to band together the nurses of all nations in a confederation of workers, to further the efficient care of the sick, and to secure the honour and the interests of the nursing profession. On July 19th next this Council will meet at the Caxton Hall, Westminster, to report progress, which, indeed, has been phenomenal, and to receive reports from almost every civilised country upon questions relating to the welfare of the sick and of the nursing profession. A strong contingent is expected from Sweden, and Canada, the United States, Holland, Finland, and Denmark will also be represented. Following the business meeting of the International Council, an International Congress of Nurses, and Nursing Exhibition, organised by the hostess Council of this country, will be held at the Caxton Hall on July 20th, 21st, 22nd, and 23rd. Another interesting session will be that presided over by Lord Sandhurst, Treasurer of St. Bartholomew's Hospital, when "The Relations of Nursing and Medicine" will be discussed. A special feature of the Nursing Exhibition will be the sections organised entirely by nurses, and illustrative of their work. All information respecting the Congress can be obtained from the Secretary, International Congress of Nurses, 431 Oxford Street, London.

# Action Against the Incorporated Dental Hospital of Ireland.

A CASE of considerable interest to the dental profession in Ireland made its first appearance in Court on Friday last in Dublin, when, in the case of "Keogh v. the Incorporated Dental Hospital of Ireland." counsel applied on behalf of the defendants for an order directing the plaintiff, Mr. Myles Keogh, dental student, to furnish the defendants full particulars of the publication of the alleged libel for which the action was brought. It appeared that last year the plaintiff applied for permission to attend the lectures at the hospital as a student, forwarding the fees, and the application was refused, the registrar writing to the plaintiff on October 20th to that effect. The alleged libel was embodied in the following resolution passed by the defendants, on May 18th, 1908:—"Resolved that Mr. Keogh cannot be accepted as a student at this hospital, the Committee having the right by their by-laws to refuse any student without assigning a cause." The plaintiff alleged that these words

would be understood by those having a knowledge of the practice of admission to the dental profession in Ireland to mean that he was unfit, unworthy, and not a proper person to attend the lectures. It was stated on affidavit on behalf of the defendants, that if there was any publication it was to persons interested.

The Court reserved judgment.

#### The Registration of Nurses.

An important meeting of the Irish Nurses' Associa-tion was held last week to consider the steps to be now before Parliament. Miss Huxley, who presided, said that the Association desired to let Mr. Asquith and others know that Irish nurses desired registration, and would strive for it until they succeeded.

On the motion of Miss Kelly, seconded by Miss

Reeves, it was resolved:-

That Irish matrons and nurses desire to record their united conviction that State Registration has become an urgent necessity for the nurses of the United Kingdom, in their own interest, and in that of the public."

On the motion of Miss Wills, seconded by Miss

Sutton, it was resolved:

"That copies of the first resolution be forwarded,

with a report of this meeting, to the Right Hon, the Prime Minister, and the Chief Secretary for Ireland."

Mr. William Field, M.P., who was present, spoke in support of the resolutions, and at the close of the meeting a vote of thanks was proposed to him by Mrs. Treacy. In doing so she referred to the union which prevailed on this subject between all Irish matrons and nurses. The Prime Minister had said that the opposition to registration in England consisted of 49 matrons of London hospitals, 109 provincial matrons, 100 London doctors, 120 provincial doctors, and 12 chairmen and treasurers of London hospitals. They must bear in mind that against these numbers they had the 20,000 members of the British Medical Association.

The Reported Presence of Prussic Acid in Chlorodyne WE have received a letter from the solicitors of Messrs. J. T. Davenport, Limited, proprietors of Dr. Collis Browne's chlorodyne, referring to a coroner's inquest held on April 27th, at which it was stated that the preparation "contained appreciable traces of prussic acid," and that "a full dose was equal to two drops of hydrocyanic acid." This statement went the round of the newspaper press, and as it was likely to undermine the value of a remedial agent which has btood the test of more than half a century, Messrs. Davenport obtained from a well-known firm of public analysts, Messrs. Helbing and Passmore, who are entirely independent in this matter, a report of the result of their analysis of two bottles of Dr. Collis Browne's Chlorodyne bought by them from different retailers' stocks, which shows that there is no prussic acid, nor any compound of it, in the chlorodyne. As is well known, there is no difficulty in ascertaining the presence of prussic acid in a compound if it is there

Messrs. J. T. Davenport, Limited.

The following is the report of the investigation by Messrs. Helbing and Passmore:-

"As requested, we have purchased at different establishments two bottles of Dr. J. Collis Browne's Chlorodyne, manufactured by J. T. Davenport, Limited, and have made a careful analysis of the same. As a result of our examination we found that neither of the two bottles of chlorodyne contained the slightest trace of prussic acid nor any compound of the same." June 7th, 1909.

The Late Dr. Conolly Norman.

THE Executive Committee recommended to a meeting of the subscribers to the Dr. Conolly Norman Memorial Fund last week that the memorial should take the form of a portrait, to be hung in the College of Physicians, and that a bust and tablet in bronze and marble should be erected in St. Patrick's Cathedral, the portrait to be painted by Miss S. C. Harrison, and the bust to be executed by Mr. Carre. It was resolved that steps should be taken to carry out the proposals as speedily as possible, and to ask the Fellows of the College of Physicians to accept the portrait, and to assign it a place to be hung.

#### Royal College of Surgeons, England.

AT the meeting of the Council of the College, held on Thursday last, the following Examiners were elected on the Board of Examiners in Anatomy and Physiology for the Fellowship for the ensuing collerhysiology for the Fellowing folice relating to the results of the results folice from the results folice for the results folice Carlier.

Carler.

The following were elected on the Conjoint Examining Board:—Elementary Biology—Thomas W. Shore, James P. Hill. Anatomy—William Wright, William H. C. Greene, Arthur Robinson. Physiology—Benjamin Moore, Ernest H. Starling. Midwifery—William R. Pollock, Walter W. H. Tate, Hugh J. M. Playfair, James H. Targett. Public Health (Part I.)—Harold Robert Dacre Spitta; (Part II.)—Richard Deane Sweeting.

#### Royal College of Surgeons of England-The Fellowship.

AT a meeting of the Council, held on Thursday, June 10th, the following members of the College, having passed the required examinations and conformed to the by-laws, were admitted Fellows of the College:

College:—

J. D. Barris, L.R.C.P.Lond., Camb. Univ., and St. Bart.'s Hosp.; W. R. Battye, Captain I.M.S., M.B., B.S.Lond., St. Thomas's and St. Bart.'s Hosp.; T. C. Clare, M.B., B.S.Lond., Birmingham Univ.; A. H. P. Dawnay, L.R.C.P.Lond., St. Thomas's Hosp.; E. A. Dorrell, L.R.C.P., D.P.H.Lond., Bristol, and St. Bart.'s Hosp.; R. Farrant, L.R.C.P.Lond., Westminster Hosp.; A. Fleming, M.B., B.S.Lond., St. Mary's Hosp.; W. H. Forshaw, L.R.C.P.Lond., Sheffield, and London Hosp.; C. H. James, Major I.M.S., L.R.C.P.Lond., St. Thomas's Hosp.; J. L. Joyce, B.A.Cantab., Camb. Univ., and St. Bart.'s Hosp.; F. A. Juler, M.B., B.A.Cantab., Camb. Univ. and St. Mary's Hosp.; C. F. L. Leipoldt, L.R.C.P. Lond., Guy's Hosp.; C. F. L. Leipoldt, L.R.C.P. Lond., Guy's Hosp.; T. W. Letchworth, M.B., B.C.Cantab., Camb. Univ. and St. Bart.'s Hosp.; Aaron Levy, M.D., B.A.McGill, Montreal and St. Bart.'s Hosp.; J. E. R. McDonagh, F.L.S., F.Z.S., L.R.C.P.Lond., St. Bart.'s Hosp.; S. G. MacDonald. M.A., M.B.Cantab., Camb. Univ. and St. Thomas's Hosp.; E. K. Martin, M.B., B.S.Lond., Univ. Coll. Hosp.; W. F. Neil, M.B., B.S. New Zealand, Otago Univ. and London Hosp.; C. Oldfield, M.D., B.S., M.R.C.P.Lond., Leeds Univ.; R. Ollerenshaw, M.D.Vict., Manchester Univ. and London Hosp.; H. R. G. Poate, M.B., C.M.Sydney, Sydney Univ. and London Hosp.; F. C. Pybus, M.B., B.S.Durham, Durham Univ. and St. Bart.'s Hosp.; H. E. Quick, M.B., B.S.Lond., Middlesex Hosp.; P. M. Smith, M.D.Lond., London Hosp.; C. F. Robertson, M.B., B.S.Lond., Middlesex Hosp.; P. M. Smith, M.D.Lond., London Hosp.; R. A. Worthington, M.B., B.A. Cantab., Camb. Univ. and London Hosp.; P. M. Smith, M.D.Lond., London Hosp.; R. A. Worthington, M.B., B.A. Cantab., Camb. Univ. and London Hosp.; P. M. Smith, M.D.Lond., Canb. Univ. and London Hosp.; P. M. Smith, M.D.Lond., London Hosp.; R. A. Worthington, M.B., B.A. Cantab., Camb. Univ. and London Hosp.; P. M. Smith, M.D.Lond., Canb. Univ. and London Hosp.; P. M. Smith, M.D.Lond., Canb. Univ. and London Hosp.; P. M. Smith, M.D.Lond. J. D. Barris, L.R.C.P.Lond., Camb. Univ., and St.

The following candidates, not being members of the

College, were also admitted Fellows:—
V. Z. Cope, M.D., B.A.Lond, St. Mary's Hosp.;
A. C. Devereux, M.B.Edin., Edin. Univ. and Middlesex Hosp.; W. M. Munby, M.B., Ch.B.Edin., Edin. Univ. and Guy's Hosp.

Diplomas of the College Licence in Dental Surgery

were granted to the following candidates:—
V. C. Burt, Charing Cross and Royal Dental Hosps;

A. Cohen, Guy's Hosp. Dental Sch.; R. Highton. Liverpool Univ. (Dental Dept.); G. G. Packe. M.R.C.S., L.R.C.P., St. George's and Royal Dental Hosps.

William John Smith, M.B.Toronto, Toronto Univ. and London Hosp., was admitted a member of the

# Summary of Recent Medical Literature, English and Foreign.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

Tuberculosis in Hospitals for the Insane.—Hutchings (Amer. Journ. of Insanity, April, 1909) discusses the incidence of tuberculosis among patients confined in asylums. The high mortality from this disease in hospitals for the insane has long been recognised, and is still present, though the old belief that such patients are peculiarly susceptible to the disease is no longer held. During the year 1906, 10 per cent. of the deaths of patients in the State of New York were caused by tuberculosis, and during the same year 16.6 per cent. of the deaths in the State hospitals for insane were caused by tuberculosis. It has further been found that the death-rate among women is higher than it is among men. Thus, in the period 1888 to 1906, there were 28,106 deaths from all causes in the New York State Hospitals for the Insane; of these, 15,242 were men, and 12,864 were women. Among the men, 1,463 died from tuberculosis—9.5 per cent.—while among the women there were 2,596, or 20.1 per cent., deaths from tuberculosis. It is not possible to state positively whether the majority of patients who develop the disease are admitted with it or are infected while in hospital, but it is quite certain that the number in the pital, but it is quite certain that the number in the latter class is at all events considerable. As regards preventive measures, Dr. Hutchings recommends careful segregation of infected patients and the use of tuberculin in order to help in making an early diagnosis. This is the great difficulty in treating tubercular insane patients, for in many cases it is not possible to make an early diagnosis of the disease in the insease by ordinary absciolar parameters. the insane by ordinary physical examination. Another very important matter is the avoidance of overcrowding. In spite of the most careful attention to ventilation and cleanliness, overcrowding has been found a most fruitful source of zymotic diseases among the The use of separate pavilions and tents for the treatment of the tubercular insane has been attended with most gratifying results in many hos-

Treatment of Pleural Effusions.—Marsden (Med. Chronicle, May, 1909) reviews the present position of our treatment of pleural effusions. There are in the main two views as to the course we should adopt in such cases. Some writers urge that the fluid should be removed as soon as its presence is recognised, and that paracentesis should be repeated whenever the fluid tends to re-accumulate. In support of this method of treatment it is urged that "no individual can be expected to derive benefit from a pleural effusion," and, further, the early removal gives less risk of cirrhosis and contraction of the lung, bronchiectasis, chronic interstitial pneumonia, and deformities of the chest. The presence of fever need not contra-indicate paracentesis, for a fall in temperature often follows the removal of the toxin-containing effusion. On the other hand, it is urged that a period of from two to three weeks should be allowed to elapse before the fluid is removed. If the fluid is removed during the stage of active inflammation, it re-accumulates rapidly, or active adhesions are likely to take place between the parietal and visceral pleura. Furthermore, it is urged the presence of the fluid is useful in giving rest to the affected lung, and so promoting the process of repair. Dr. Marsden's experience leads him to accept the former teaching, and he believes that the danger of a permanently contracted lung is much greater than is the danger of the formation of adhesions. K.

Excessive Growth of the Beard.—Allworthy (Brit. Journ. of Dermatology, May, 1909) records the case of a man whose beard grew with extraordinary luxuriance. At one period it measured 130 inches in length, in spite of the fact that at times, owing to the hair having become matted and unmanageable, he

had been compelled to cut off considerable portions. The man died when sixty-four years of age, his throat and chest having suffered as the result of the experiment.

K.

Intercostal Rigidity in Lung Disease.—Pottenger (Amer. Journ. of the Med. Sciences, May, 1909) lays stress on the importance of spasm of the intercostal muscles over areas of the lung affected with tuber-culosis as an aid to diagnosis. Pottenger has found this sign constant even in very early cases of the disease, and by its means he believes that he is able to; map out the affected areas of the lung. K.

Prostate Weighing Seventeen Ounces Removed by Suprapubic Route.—Fullerton (Brit. Med. Journ, 22nd May, 1909) reports the case of a patient, æt. 73, who had little urinary trouble until he suffered from retention of urine two days before the operation. There was some hæmaturia, and catheterisation failed to relieve the condition owing to the instrument getting blocked with clot. Suprapubic puncture was resorted to. As the patient had had a severe syncopal attack a few days before owing to weak heart, it was with some misgiving that operation was decided on. The operation was accompanied by the greatest difficulty, on account of the finger being unable to reach the deeper part of the gland. In order to deliver the prostate it was found necessary to split it longitudinally, and remove it in halves. The operation was conducted under ethyl chloride, and lasted fifteen minutes. The patient suffered from very severe shock for some hours after the operation, but subsequently did well. A small mulberry calculus was also removed from the bladder.

Partial Thyroidectomy.—Dunhill (Brit. Med. Journ., 22nd May, 1909) gives his experience of this operation on 113 cases. Two of these were for malignant on 113 cases. Two of these were for malignant goitre, 88 for exophthalmic goitre, with one death early in the series. Twenty-three were performed for the parenchymatous or adenomatous variety without a death. All the cases were done under local anæsthetic. death. All the cases were done under local anæsthetic. Local anæsthesia is very much safer, there is less danger of injuring the recurrent laryngeal nerve; it is not followed by vomiting and retching, which is extremely painful and may lead to secondary hæmorrhage. Local anæsthesia also permits the patient drinking three pints of water within the first two or three hours after constraints. two or three hours after operation, which the author insists on as a prophylactic for any tendency to acute thyroidism. The writer's results have been very satisfactory even in cases in which the symptoms have progressed until organic changes have taken place in heart muscle. The author considers that every should be treated medically for about three the heart muscle. months if there is continuous improvement, which shows definite signs of going on to complete cure. Operation should be performed as soon as it is recognised that the patient is not improving, and before she has lost so much ground that she will require much nursing back to health after the cause of the disease is removed. The nutber werell the cause of the disease is removed. The author usually removes one lobe and half the isthmus at one sitting, and if that is not sufficient, half the second lobe a few months later. He is strongly averse to the crushing of the gland before its division. This procedure is not necessary to control hamorrhage, and the toxic secretions from the bruised glandular tissue are absorbed by the veins and lymphatics, giving rise to acute thyroidism. The author inserts a glass drainage tube for two days down the raw surface of the cut lobe through a separate incision, and says that the amount of blood-stained secretion that is got rid of into the dressings is sometimes amazing. This thryotoxin would be otherwise absorbed with perhaps fatal results.

## **NOTICES TO** CORRESPONDENTS, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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CONTRIBUTORS are kindly requested to send their communica-

CONTRIBUTORS are kindly requested to send their communica-tions, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

JOHNSON ON GOUT.

A CORRESPONDENT has sent us the following, culled from the original "Life of Johnson":—Dr. Samuel Johnson, being attacked by gout at the age of 66, wrote to Boswell on July 6th, with this couplet:

What dignity attends the solemn gout;

What conscious greatness if the heart be stout.

MISTERCORDIA.—Apply to the Medical Officer of Health for the

Miserscordia.—Apply to the medical officer of account district.

Dr. S. M.—The work you speak of is conceived in the true scientific spirit of patience and humility. If true, it must one day secure recognition at the hands of the profession, although, unfortunately, the recognition is so tardy as to be of little avail to the earnest worker. That your theory expresses part of the truth appears to us fairly certain, that it may lead to the discovery of the whole truth appears probable. Meanwhile, right or wrong, it forms a valuable contribution to contemporary methods.

THREE PHASES OF A PHYSICIAN.

CORDUS, the Physician, who was in the habit of taking his fees at the termination of his patient's disease, described the practitioner in three different characters in a facetious epigram, which has been thus translated:—

Three faces wears the doctor: when first sought, An angel's—and a god's the cure half wrought; But when that cure complete, he seeks his fee, The devil looks less terrible than he.

The sentiment contained in this jeu d'esprit recalls the old couplet:— THREE PHASES OF A PHYSICIAN

The sentiment contained in this jeu d'esprit recalls the old couplet:

"The Devil was ill, the Devil a saint would be;

The Devil was well, the devil a saint was he;

M.D.Glasse. (South London).—If in doubt, you had better try Calmette's test—a drop of tuberculin solution (glycerin. free) is placed on the conjunctiva, and if the patient be tuberculous, this proceeding is followed by a conjunctivitis within six to fourteen or sixteen hours. A positive reaction is of the greatest value, but a negative result does not exclude the infection, and in that event the test should be repeated two or three times.

W. T. G.—The occasion was a special one, and the space limited. Perforce, therefore, the invitations had necessarily to be limited.

GENERAL PRACTITIONER.—An apology having been made, and the circumstances fully explained, we cannot see that our correspondent would gain anything by pursuing the case further.

# Meetings of the Societies, Tectures, &c.

WEDLESDAT, JUNE 16TH.

ROTAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—
8 p.m.: Dr. J. A. Braxton Hicks: Exhibition of the Better-known Tropical Parasites.
MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. J. Freyer Clinique (Surgical).
5.15 p.m.: Lecture: Mr. C. Dent: Persistent Symptoms after Head Injuries.

Head Injuries.

NORTH-EAST LONDON FOST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. B. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. P. Brooks).

ROTAL SOCIETY OF MEDICINE (DERMATOLOGICAL SECTION) (20 Hanover Square, W.).—5 p.m.: Dr. Wilfred Fox and Dr. Rolleston: A Case of Leuksemic Infiltration of the Skin. And other Cases.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—
5 p.m.: Dr. W. S. Lazarus-Barlow: Radioactivity and Carcinoma (an Experimental Inquiry). (Croonian Lectures.)

MEDICAL GRADUATES' COLLEGE AND POLICLINIC (22 Chemies-Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical), 5.15 p.m.: Lecture: Mr. E. Corner: Affections of the Umbilious.

Umbilious.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynsecological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X.-Rays. 5 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture-Demonstration: Mr. A. de Prenderville: On the Administration of Ansethetics.

ministration of Anesthetics.

PRIDAT, JUNE 18TH.

ROYAL SOCIETY OF MEDICINE (SECTION FOR THE STUDY OF DISEASE IN CRILDREN) (20 Hanover Square, W.).—Provincial Meetings at Edinburgh. N.B.—Fellows of the Society are entitled to attend and to speak at all Meetings.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies-Street, W.C.).—4 p.m.: Mr. M. S. Mayou: Clinique (Eye).

NORTH-East London Post Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Cllinic: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Operations: (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

Central London Throat and Ear Hospital (Gray's Indread, W.C.).—5.45 p.m.: Lecture: Dr. Abererombie: Pharynx and Naso-Pharynx.

## Appointments.

HEATH, A. D., M.D.Lond., M.R.C.S., M.R.C.P.Lond., Physician-in-Charge of the Skin Department of the General Hospital, Birmingham.

MASSON, CHARLES ARMIT, M.B., Ch.B.Aberd., Senior Assistant Physician at Inverness District Asylum.

MCKILLOP, A. C., M.B., Ch.B.Edin., Junior Assistant Physician at Inverness District Asylum.

MOORE, IRWIN, M.B., C.M., Assistant Surgeon to the London Throat Hospital.

NIALL, W. G., M.D., M.S.R.U.I., Medical Officer to the Guildford No. 2 District.

#### Bacancies.

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Northern Infirmary.—House Surgeon. Salary, £100 per annum. with board, etc. Applications to Mr. Duncan Shaw, W.S., Inverness.

Birmingham General Dispensary.—Resident Surgeons. Salary, £170 per annum, with furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.

Royal Surrey County Hospital, Guildford.—House Surgeon. Salary, £100 per annum, with board, residence, and laundry. Applications to the Hon. Secretary at the Hospital.

Brecon and Radnor Asylum, Talgarth, Breconshire.—Assistant Medical Officer. Salary, £170 per annum, with board, furnished apartments, attendance, and laundry. Applications to the Medical Superintendent.

Royal South Hants and Southampton Hospital.—House Physician. Salary, £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher-Hall, Secretary.

Weston super-Mare Hospital.—House Surgeon. Salary, £100 per annum, with board and residence in the Hospital. Applications to the Hon. Secretary.

Sheffield Union Hospital.—Assistant Medical Officer. Salary, £100 per annum, with apartments and rations. Applications to Albert Edwd. Booker, Clerk to the Guardians, Union Offices, Sheffield.

East London Hospital for Children and Dispensary for Women. Shadwell, E.—Resident Medical Officer. Salary, £100 per annum, with board, residence, and laundry. Applications to W. M. Wilcox, Secretary.

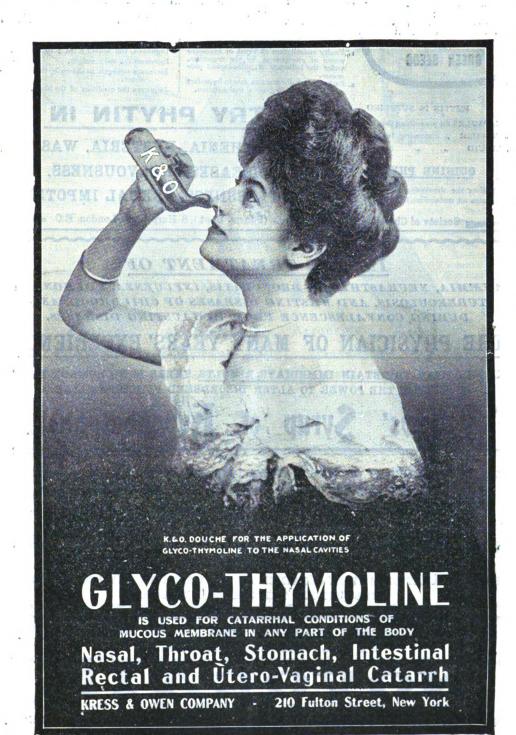
West Riding Asylum, Menston, near Leeds.—Fourth Assistant Medical Officer. Salary, £106 per annum, with board and apartments. Applications to the Medical Superintendent. London County Asylum, Colney Hatch, New Southgate, N—Junior Assistant Medical Officer. Salary, £160 a year, with board, furnished apartments, and washing. Applications to H. F. Keene. Clerk of the Asylums Committee, Asylums Committee, Asylums Committee, Officer, Salary, £100 per annum, with board apartments and partments applications to Headen Place, London, S.W.

### Births.

CRAIG.—On June 7th, 1909, at 18 Merrion Square, Dublin, the wife of James Craig, M.D., F.R.C.P.I., of twin sons Fox.—On June 10th, at Beccles, Suffolk, the wife of George E. Fox, F.R.C.S., J.P., of a daughter.
Jewesbury.—On June 10th, at Stoughton, Guildford, the wife of R. C. Jewesbury, M.B.Oxon., M.R.C.P.Lond., of a son Montgomery.—On June 10th, at "Fermain." Maidenhead, the wife (nee de Steig?r) of Edwin Cecil Montgomery, M.R.C.S Eng., L.R.C.P.Lond., of a daughter.

### Beaths.

DIAMOND.—On June 8th, Victoria Gonville, wife of W. H. Diamond, M.D., and daughter of the late Sir Gonville Bromhead, Bart., of Thurlby, Lincolnshite, aged 66 years.



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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII.

WEDNESDAY, JUNE 23, 1909.

No. 25.

# Notes and Comments.

SINCE the time of Hunter's famous experiment of the successful graft-The Transplantation ing of the cock's spur into its comb, of Limbs. many interesting essays have been made in a similar direction. Teeth, skin, bones, nerves and blood-vessels have all been transplanted, and success has been reported even with the kidneys of smaller animals. If some results recently published by Dr. Alexis Carroll, of the Rockfeller Institute, of New York, are confirmed, medical science may be said to have added another substantial fact to the foundation of future achievements. Dr. Carroll's first attempt to transfer the leg of one dog to that of another had practically succeeded when the fox-terrier that was the subject of the experiment unfortunately died of pneumonia. A second attempt is said to have had a more favourable result, and the two dogs were said to be "getting on very well with their grafted legs." If this can be done in the case of dogs, there is no particular reason why a similar transplantation should not be practicable in the case of man. Should some millionaire have the misfortune to lose a leg or an arm, it would probably be within the purchasing power of his money to procure a limb for the purpose of grafting from some fellow mortal less richly endowed with worldly pelf. Meanwhile, the operation is hardly within the range of practical surgical politics. Its chief purpose in life at present seems to be to give a delightful opening to the raging propaganda of the anti-vivisectionists.

contemporary, OUR sprightly "John Bull's" John Bull, eager to emulate the feats of its sixpenny prototype in the exposure of scandals—but, apparently, without that proto-Biscuit Manufactory. type's command of machinery for verifying information—is becoming extraordinarily au fait at discovering mares' nests. It is but two or three weeks ago since it was let in over a pièce de résistance for the week, which was placarded over the Kingdom. The editor had no idea that he was not printing a fresh and piquant article, but he really should be on his guard against believing everything that is told him. His ingenuousness and his confidence in the essential accuracy of human nature would do more credit to-let us saya Don Quixote than to a London editor who aims at being smart. More unfortunate even than the aforesaid fiasco is the series of articles on lunacy scandals which he has been endeavouring to work up, for they involve much unnecessary publicity in matters which are best buried in the sanctuary of private life. In a recent issue he discovers that repeated attempts at suicide are evidence of insanity, or, at least, that prodromal symptoms of insanity recognised by medical men may in a short time lead to suicide. If John Bull had that knowledge of the world which is possessed by the man in the street, to say nothing of medical men, he would know that half the patients in asylums are strongly convinced of their own sanity, and equally strongly of the loss of mental stability in their comrades in misfortune. Wherefore let us urge our contemporary to beware of the perils of biscuit manufacturing which it seeks to impress on its fellows. The pleasure of distributing biscuits is no doubt great; the task of preparing them for distribution is beset with pitfalls.

A Musical Medico. The justices of Colwyn Bay are being much exercised in their minds as to whether or not they have been hoaxed about a medical certificate.

A Manchester woman was summoned to appear before them to answer a charge of defrauding a railway company. When the day for hearing arrived, the defendant did not appear, but a certificate arrived by post saying that she was not able to attend on account of "serious illness." The document was signed "W. Miller," and the kindly disposed bench adjourned the case for a week. At this adjourned hearing, however, the defendant again was not present, and a detective was called for the company, who explained that he had been to see the woman, and asked her about "Dr." Miller. To him she pointed out that the said Miller was not a doctor, but "a friend who went to play music to her every night"! The friend's address was asked for, and two or three different ones were given, and finally, said the detective, he was asked to call next day, when the woman hoped she could give it correctly. This evidence seemed to have ruffled the bench, for the chairman breathed dark threats about issuing a warrant if the defendant did not appear at the next sitting. We do not think the bench really have much ground for complaint, even if the facts are as stated, for the "W. Miller" in question made no pretence to being a medical man, and if a certificate is lightly accepted without inquiry as to the identity of the giver, there is no reason why the latter should not be a friend who "plays music every night," if he likes to take the responsibility of certifying.

Medical
"Freedom."
WE are always somewhat amused at the doings of the "People's League of Medical Freedom," and we have never been able to understand what class of medical "freedom" the people of this country do not enjoy. Every man is free to go to the doctor he likes, the

quack or herbalist he affects, to buy the medicine he likes, with the exception of a few scheduled poisons, which under the new Pharmacy Act he can now get in any quantity he desires at a horticultural dealer's if a pharmacist refuses to serve him. A recent meeting of the League at Southport, however, has given us a hint of what that body really desires. They object to the practice of coroners holding inquests on people who die without benefit of registered medical practitioners, and we can quite understand why the "People" find this custom inconvenient. It is awkward for the adherents of herbalists and similar freebooting practitioners when an inquest is held on a person who has died during an illness attributed to "worms" or "sluggishness of the blood," and the post-mortem reveals an appendicular abscess or such condition curable by ordinary surgical methods. At the meeting in question the following resolution was adopted:—"That this meeting expresses its gratification at the demand for medical freedom which is now being made by unorthodox schools of medical practice, as evidenced (1) by the efforts of the medical herbalists to obtain a charter; (2) by the recent determination of the homœopaths to establish a college for the training of their students; and (3) by the increasing activity of the Nature Cure Association, the Emmanuel Society, and other like organisations." We cannot help wondering if the homoeopaths will be flattered by finding themselves dans cette galère.

Anæsthetics for Animals.

INTERESTING stories are told by the Daily News of anæsthetics given of late years to animals for surgical and other purposes, stories which, in some instances, put a certain strain on the

credulity, but which we feel we can accept without reserve on the authority of our contemporary. We are told of a chimpanzee and a "particularly ferocious" lynx which were anæsthetised for surgical operations at the Zoo, and a rhinoceros (in New York) which needed a pound and three-quarters of chloroform and half a pound of ether before sinking into oblivion. Also of a lion, at Earl's Court Exhibition, which lost an eye and was supplied with an artificial substitute. The lion, accustomed to the realities of life, promptly scratched out this aid to comeliness when he came round from the anæsthetic, we are informed. Of this story we may say that we have no difficulty in believing the second part if we are prepared to swallow the first. The greatest trial, however, is when we are informed that fish in the Prince of Monaco's Oceanographic Institute were chloroformed in order that photographs might be taken of them, especially as the incident is narrated without the horror and aversion of our contemporary. Is it not rather inconsistent of a rabid anti-vivisection organ to pass lightly over experiments made on fish for purposes of photography and to rave furiously against an experimenter who inoculates a guinea-pig that he may save a child?

Mr. Chapman and Treatment.

THE "Normyl" treatment of alcoholism has been so little to the fore of late that we had begun to think the "Normyl" it had taken its place with the other innumerable cures which have preceded it into oblivion.

However, a report has just been published in the press by the Rev. Hugh Chapman, the honorary secretary of the "Normyl" Association. The report gives little or nothing in detail as to the results of the treatment, but consists for the most part of a repetition of the old claims made on its

behalf. It is significant, however, that the encomiums are pitched in rather a lower key, and there are one or two remarks which seem to possess an interesting significance. Mr. Chapman disclaims the secret cure of the drunkard, but says: "I am profoundly impressed by the value of religion in this connection, my own experience being that the vast majority of those tempted to drink have a certain disposition towards devotion. . . . must be a desire to be cured, and the immense help of hope, a re-awakening of love which is the death-blow of selfishness, and a willingness to observe the conditions. . . . Abstinence from alcohol during the treatment (twenty-four days) and regular recourse to the medicine are the sole con-Normyl will do the rest." Of this we can only say that, given a man addicted to drink who is filled with a desire to be cured, who is of devotional temperament and seeks the aid of his religion, who is determined to eschew selfishness. who is strong in hope of being cured, and who will begin by keeping from alcohol for nearly a month, given all these conditions, and Normyl or any other drug has precicus little to do. Long before any drugs were used for alcoholism men have turned from strong drink by the aid of repentance, religion and a desire for a new life. The Salvation Army can supply examples ad lib.

### LEADING ARTICLES.

THE LUST FOR BLOOD AND THE INSANE HOMICIDE.

THE recent occurrence in Liverpool of a series of murderous attacks upon women has once again brought into prominence the existence of a curious form of criminal homicide, of which it is difficult to fathom the motive. In the present instance the assaults have all been committed within a restricted area, and have extended over six weeks. During that period a large number of women, some of them having been decoyed into alleys and stabbed with a sharp instrument, while others have been similarly attacked in the street. Fortunately none of the victims have been mortally wounded, although in some instances abdominal wounds of a most serious nature have been inflicted. most recent attack a young woman was accosted in the street by a man who had the appearance of a foreigner, but, suddenly, noting the glint of steel in his hand, she gave an alarm, which resulted ultimately in the aprehension of a man, who may or may not be the author of a series of crimes. Under the circumstances it is, of course, out of the question to comment upon the case, but as a considerable amount of attention has been drawn to these sensational occurrences, it may be desirable to put forward a few remarks upon the general aspects of homicidal attacks of this particular kind. The instance that at once occurs to the mind is that of the series of murders of unfortunate women that took place in London in the years 1888 and 1889. In all there were eleven victims, who were rapidly disembowelled and the viscera removed in a manner that suggested the murderer was possessed of anatomical knowledge, and that earned for him the popular sobriquet of "Jack the Ripper." The author of this extraordinary series of crimes was never brought to light, but the fixed popular belief is that he died later in a criminal lunatic asylum. A somewhat similar set of murders has recently

baffled the police of Berlin. The lack of a prominent motive and the facts attendant upon these crimes at once suggest they are the outcome of insanity. They are, in short, the work of human tigers, in whom there is a predominating lust for blood, which can be satisfied only by the sacrifice of certain victims in a given manner. The subject was recently touched upon by Dr. Claye Shaw, in an address delivered before the Medico-Legal Society on "A Prominent Motive in Murder." The main subject dealt with is the lust for blood, to which he has given the name "hæmothymia." He points out that when the intellectual side of his mind leads a man to commit a crime, delusional insanity is fairly easily held to mitigate his responsibility. On the other hand, as regards a similar influence from the emotional side, however strong and compelling in its force, however morbid in intensity, the plea of "affective" or "emotional" insanity is rarely, if ever, put forward, except save, possibly, as an extenuating circumstance. Yet feeling and emotion are the wellsprings of action in life. The ultimate origin of the fight for life, for food, for progress, for social safety, is to be found essentially in the tapping of the emotional or affective promptings. Indeed, says Dr. Shaw, "will itself is so largely made up of emotional element that it is doubtful if it could exist without it; certainly, any preponderance or diminution in the intensity of the emotional part of the content of any state of willing must seriously affect its validity." The blood lust appears to fall well within the emotional field. The sight or smell of blood affect most living creatures of the higher types in a curious way. It is obvious that in savage states the sight, smell, and sometimes the taste, of blood must be closely connected with the preservation of life by the procuring of animal food and by the destruction of foes, and that these associations must play an important part in the evolutionary stages of the mammalian brain and in its most highly-finished product in the genus homo. It is possible that the French Revolution was prolonged by the continual flow of blood from the guillotine. In hand-to-hand fighting, again, the fury and the desire to kill are more intense than under modern methods at long ranges. The problem, from a pathological point of view, is, what state of mind can that be which, without external provocation, prompts to an apparently uncontrollable desire for blood, as in the Jack the Ripper cases? Dr. Shaw's view is that there is probably an emotional complex present, not merely the desire for blood, but also an admixture with the love of notoriety, of a wish to frighten the public, and of self-satisfaction at finding the prominence attained, the last acting as an incentive to repetition of the process to feed the flame of vanity." A further influence appears to be that the lust for blood grows in intensity, possibly also from indulgence, until it becomes ideomotor. After all said and done, we feel that modern psychology has yet much to discover in the analysis of the mental processes that can produce so monstrous a type as that of the multiple murderer of the "Jack the Ripper" type. From a more practical point of view, it may be urged upon the experts in insanity that possibly prevention may, in this

direction, prove better than attempts at cure. For instance, it would be well to devote some of the vast capital and energy now expended in the care of the insane towards the prevention of the marriage of the unfit. This may be done both by educating the nation as to the undesirability of persons of insane stock, and of the absolute necessity of putting an end to the short-sighted and, to our minds, absolutely indefensible practice of discharging so-called "cured" inmates from lunatic asylums, and allowing them to breed freely and thereby multiply lunacy upon the face of the earth. Were this practice stopped a great step would have been taken in advance with regard to the diminution of criminal lunacy of all kinds and degree.

### CURRENT TOPICS.

### Post-Mortem Examinations in Workhouses.

THERE are in some quarters sentimental objectors to the making of post-mortem examinations, just as there are objectors to dissection, to vaccination, to experimental research, to orthodox drug treatment, and, indeed, to all and every branch of scientific medical research and practice. At this time of day, however, it comes somewhat as a shock to find certain guardians of a first-rate provincial city banning the holding of post-mortems in workhouse hospitals with bell, book and candle. Yet that is what occurred recently at Manchester in connection with the Withington Workhouse Hospital. Mrs. Garrett, one of the guardians, objected to the holding of post-mortems on the ground that, no reports being made, they were of advantage to no one except the medical man who performed them. She added that she was opposed altogether to the granting of this "liberty" to young doctors who came to their institution, making the hospital a practising-ground for the completion of their education. These remarks, we gather from the Manchester Evening Chronicle, were supported by a "Dr. Garrett," who held that post-mortems in these institutions should be placed on the same footing as in the case of the wealthy, where they took place only and solely when there were suspicions of foul play. With regard to the latter contention, it may be remarked generally that the post-mortem examination is absolutely indispensable for the progress of medical knowledge, and that it is not infrequently permitted by educated persons on purely scientific grounds. As to the remarks of the lady guardian, we can only say that if fully-educated and experienced medical officers are required, their services must be paid for at corresponding rates. Moreover, it is absolutely necessary that every medical man must go through his educational experience somewhere or other, and the least that the community may expect in return for their support of voluntary and of State medical institutions is that they be reasonably, discreetly and humanely used as training centres for medical men. Sentiment of the flabby kind that would forbid post-mortems is akin to that of the anti-vivisectionist who declaims against a scientific experiment on a lower animal, but who does not hesitate to eat a lobster that has been boiled alive, or to allow his wife to wear egret feathers

torn from a nesting bird, or haply to play a salmon for an hour or two before that noble fish is brought to gaff.

# Poor-law Medical Officers and the Budget.

In many quarters an outcry has been raised against the increased expenses imposed on individuals by the recent Budget. Of these complaints some are sound, some questionable, and others unwarranted by the facts of the case. Amongst the "hard cases," however, is undoubtedly that of the Poor-law medical officers who have to provide their own drugs. As a rule, they are badly paid, while in some instances the allowances are scandalously low. In any event, the Poor-law medical officers are obliged to consider ways and means most carefully, and their financial balance is likely to be seriously disturbed, if not annihilated, by the extra cost of drugs, due to the increase of spirit duties. However, there is a ray of hope in most valleys of despair, and it may here be found in the direction of cheaper preparations. With a little ingenuity and a fair acquaintance with the resources of the Pharmacopœia, it is possible in a vast number of cases to substitute (we use the word in its original sense) watery solutions, extracts, preparations of active principles, and so on, in place of the spirituous preparations. Any capable pharmacist could effect a great saving in this way without any damage to therapeutic efficiency. The lesson of economy in drugs is one that ought to be inculcated with advantage in our voluntary as well as our Poor-law medical institutions.

### Strawberry Culture in England.

THE importance of fruit culture in the United Kingdom is perhaps hardy realised as a national asset, although of late years it has undoubtedly undergone great and encouraging developments. Under present conditions a great deal of money goes out of the country for produce that could be just as readily and cheaply grown at home. The dearness of land and the cost of railway carriage are not remotely concerned with this untoward result. Meanwhile, one of our best fruit crops is the strawberry, for which the soil and climate of the British islands is peculiarly favourable. It is of value, not only as a fresh fruit, but for the production of a staple foodstuff in the shape of jam. In our desire to maintain the reputation of this wholesome and delicious fruit in our issue of June 9th we condemned a practice that has grown up in certain quarters of placing rotten manure under the ripe berries to keep them off the soil. The practice is clearly prejudicial to the health of consumers, and we suggested that it should claim the attention of medical officers of health in strawberry-growing districts. We have since received a letter from a gentleman, who writes on behalf of the Hampshire growers, and indignantly repudiates the practice so far as that county is concerned. We gladly receive the assurance that clean straw is used by the Hampshire fruit gardeners, but that fact does not disturb our trustworthy information that in certain other parts of England rotten means is freely used. The matter

seems to be worthy of a question in Parliament, and of the attention of the Local Government Board, if to that body, as we imagine, pertains the duty of controlling the sanitary conditions under which is produced a foodstuff consumed to so enormous an extent as the strawberry.

## Education and Medical Advice.

In England, during the past few years, much has been done to bring the educational system of the country into relation with medical opinion. The regular inspection of school-children, with the constant visits to the school thereby entailed, renders it almost impossible for any radical fault of school management or arrangement to escapenotice. In Ireland, on the other hand, medical menhave no connection with the primary or secondary school system, and no detail of school work comesunder their notice or control. As is natural, such a condition has led to very serious results. As we have often pointed out, the school buildings are notoriously unsuitable from a sanitary point of view. The arrangement of school work, as regards hours, examination system, and so on, has been framed without any regard to the health of the children. The National and Intermediate Boards of Education are without any expert advice in sanitary or medical affairs. We are glad to see that the Irish Medical Association has had its attention drawn to the matter. At the Sligo meeting a couple of weeks ago, on the motion of Mr. J. B. Story, of Dublin, a resolution was passed demanding the appointment of a medical man on each of the educational boards of the country. Ifhowever, this resolution is to have any force, it must be pressed on the authorities by agitation in Parliament and elsewhere. It is a pity that the Irish Medical Association missed a chance of demanding the appointment of medical men as inspectors under the Intermediate Board a few months ago, when, for the first time, that Board introduced a system of inspection.

# The Annual Meeting of the British Medical Association in Beltast.

It is over twenty years since the British Medical Association held a meeting in Ireland, and consequently considerable interest is being taken in the meeting to be held next month in Belfast. programme of business is gradually approaching completion, and in many of the sections subjects of special interest are down for discussion. Thus in the Section of Medicine the main discussion will be on angina pectoris, to be introduced by Sir Clifferd Allbutt. In the Section of Obstetrics Dr. Hastings Tweedy, Master of the Rotunda, will open a discussion on the fruitful, if unsatisfactory, subject of endometritis. A new feature is a section of Hæmatology and Vaccine Therapy, of which, as is natural, Sir Almroth Wright is President. He will give an opening address dealing generally with the subject of vaccine therapy. A less necessary section is that of Pharmacology and Therapeutics; the subjects to be dealt with here might easily have been disposed to other sections, and the multiplication of sections is unwise. As in previous years, a pathological museum is to be a feature of

PERSONAL.

the meeting, and collections of specimens dealing with tuberculosis, diseases of warm climates, cancer of the uterus, and X-rays, are being specially made. When we add that arrangements are in hand for pleasant engagements of a social nature, it will be seen that any members of the profession who can visit Belfast next month may be sure of enjoying the meeting.

### PERSONAL.

Dr. Lazarus-Barlow delivered, on the 17th inst., the second of the Croonian lectures on "Radio-activity and Cancer."

AT a Garden Party on July 8th, at 3.15 p.m., the medals and prizes at Guy's Hospital will be distributed to the students by His Grace the Duke of Devonshire.

The President of the Board of Education has appointed Mr. Ralph H. Crowley, M.D., M.R.C.P., to be an assistant medical officer of the Board. Dr. Crowley, who was for some time honorary physician of the Bradford Royal Infirmary, at present occupies the post of medical superintendent of the Bradford Local Education Authority.

The League of Mercy announces that the Comptroller of H.R.H. the Prince of Wales's Household has issued invitations in the name of T.R.H. the Prince and Princess of Wales, Grand President and Lady Grand President of the League of Mercy, to a reception at Marlborough House on July 7th.

THE Medical School of St. Thomas's Hospital will hold its annual prize-giving on Friday, June 25th, at 3 p.m. The prizes will be distributed to the students by the Rt. Hon. Alfred Lyttelton, K.C., M.P., in the Governors' Hall.

THE Annual General Meeting of the Research Defence Society will be held at the house of the Royal Society of Medicine, 20 Hanover Square, W., on Friday, June 25th, at 5 o'clock. The Earl of Cromer, President of the Society, will take the chair. Other speakers will be Sir James Dewar, Sir Arthur Conan Doyle, the Hon. Walter Guinness, and Professor Starling.

Dr. W. Wynn Westcott, J.P., Coroner for North-East London, was yesterday elected President of the Coroners' Society of England and Wales, and Mr. Walter Schröder, Deputy Coroner for Central London, was re-appointed honorary secretary of the Society.

A COMPLIMENTARY dinner was given at the Grand Hotel, Charing Cross, on the 17th inst., to Dr. J. F. W. Tatham, who is retiring from the office of Superintendent of Statistics at the General Register Office.

The annual Welsh medical dinner was held in London, on June 15th. Dr. D. C. Lloyd Owen, F.R.C.S., was chairman, and amongst those present were Sir John Tweedy, Mr. Henry Morris, P.R.C.S., Mr. Ellis Griffith, M.P., Messrs. Lynn Thomas, C.B. and Howell Evans (hon. secretary of the committee)

THE Finsbury Borough Council have appointed as Medical Officer of Health Dr. A. E. Thomas, of Chester, in succession to Dr. Porter, who has been appointed Medical Officer of Health to the Borough of Marylebone.

THE Prince of Wales, on the occasion of his visit to Midsomer Norton, Somerset, on June 23rd, will present the badge of hon associate of the Order of St. John of Jerusalem in England, of which he is Grand Prior, to Dr. Worger, of Radstock, and the society's vellum certificate to Mr. Lloyd Harvey, of Radstock, for services rendered by them for ten years to the cause of first aid to the injured.

DR. OTT, of Marienbad, who attends King Edward during his visits to the Bohemian Spa, has been summoned to London to examine and report upon the King's condition. It is believed that it will depend upon Dr. Ott's opinion whether King Edward will go to Marienbad this summer or to some other spa.

AT a meeting of the Royal Humane Society in London a testimonial was awarded to Dr. Harry Brown, the Medical Officer of the Lunatic Asylum, Pretoria, for his attempt to rescue a man who was drowned while bathing in a disused quarry there on February 3rd. After diving three times into the quarry, the bottom of which is covered with barbed wire, Dr. Brown got the man out, but too late to save his life.

Dr. John Hall, of London, a medical graduate of Glasgow University in 1859, has left the balance of his estate, estimated at about £35,000, to the Senate of the University of Glasgow as an endowment for the foundation of tutorial fellowships in connection with the study of surgery, medicine, and midwifery at that University, to be called "Hall Tutorial Fellowships." The election is to be made by a body consisting of the professors of surgery, medicine, and midwifery; and the fellowships are to be awarded after examination. Each of the fellowships is to be of the value of £200 per annum, and to be paid in advance at the beginning of each session, and there are to be as many of these fellowships as the income will admit.

DR. EDWARD BLAND, of Sandiacre, Derby, who died on April 9th, left estate of the gross value of £12,390, with net personalty £9.125. He bequeathed £500 each to the Midland Institution for the Blind, Dr. Barnardo's Homes, the National Lifeboat Institution, and the Nottingham General Hospital; £200 to the Nottingham Children's Hospital; and £100 each to the Nottingham General Dispensary, the Nottingham County Cricket Club, the vicar of Sandiacre for charitable purposes. The residue of his estate is left for the erection of four almshouses in Sandiacre, to be known as the "Bland Almshouses."

This year the meeting of the British Association will be held at Winnipeg, Manitoba, under the presidency of Professor Sir J. J. Thomson. The inaugural meeting will take place on August 25th, when Professor Thomson will assume the presidency in succession to Mr. Francis Darwin, and will deliver an address. The following day the sectional meetings will commence, and the sittings will extend to September 1st.

Professor E. Rutherford will preside over the Mathematical and Physical Science section. The other presidents of sections are: Chemistry, Professor H. E. Armstrong; Geology, Mr. A. Smith-Woodward; Zoology, Mr. A. E. Shipley; Anthropology, Professor J. L. Myers; Physiology, Professor E. H. Starling.

TWENTY-FOUR cases of cholera and one death from the disease were notified in St. Petersburg on June 17th. Altogether there are 111 patients suffering from cholera in hospital.

HIS MAJESTY'S ship *Philomel*, which has been for some months on the Somali coast, has been ordered to Colombo in consequence of a serious outbreak of scurvy among her crew. The Sirdar will in consequence proceed to Egypt by mail steamer.

# A CLINICAL LECTURE

ON THE

## TREATMENT AND DIET IN INFANTILE GASTRO-ENTERITIS.

By PROFESSOR LEON DELMAS, M.D., .
Of the Faculty of Medicine of Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

GASTRO-INTESTINAL disturbances are especially frequent in the young during the hot season, owing to the peculiar vulnerability of the digestive tract during the first two years of life, more particularly during the first few months of life. Dentition used to be regarded as the most important factor in the production of infantile enteritis, but it is now relegated to a secondary position.

Infantile diarrhœa is met with in infants brought up at the breast in whom it occurs almost invariably in the form of fugitive indigestion or slight catarrhal enteritis. In some instances infants brought up at the breast by wet nurses, who are in the best of health, nevertheless suffer from diarrhœa. This may be explained by the fact that the diarrhœa is mainly due to the influence of the external temperature even more than the food, for the simple reason that the external temperature modifies the intestinal flora and provokes intestinal catarrh; this diarrhœa is, as a rule, a mild affection.

The same remarks apply to infants fed on sterilised milk, provided that the milk is sterilised on the spot. In course of transit non-sterilised milk will have fermented, and the injurious substances resulting from this fermentation resist late sterilisation. It is, however, especially in the bottle that the changes take place, and bottles with long rubber tubes are particularly dangerous.

Statistics show that the mortality during the first year of life constitutes something like one-quarter of the total mortality, and that about one-half, sometimes more than one-half, of the infants dying during the first year succumb to affections of the digestive tract.

Infantile diarrhœa presents different clinical types which it is important for practitioners to be familiar with from the point of view of both prognosis and treatment, but we cannot deal with these on the present occasion. Suffice it to say that simple acute grastro-enteritis sometimes comes on suddenly in the midst of health, with vomiting, fever and colic. As a rule it is preceded for some days or weeks by dyspeptic disturbances such as sickness, flatulence, alternations of constipation and diarrhœa, etc. Once it has supervened, the attack of enteritis may assume either a grave or a mild form.

The mild form is almost always primary; it is ushered in by more or less marked febrile symptoms, such as a flushed face, a rapid pulse, a hot skin, thirst and loss of appetite. The abdominal symptoms, however, attract most attention. The child is in pain, as shown by its restlessness, its incessant crying, and the drawing up of the legs on the abdomen, pressure over the belly is painful and makes the child scream. The stools are frequent, liquid and copious. Yellow to begin with, though mixed with mucus and undigested casein, and occasionally streaked with blood, they soon become green. The tongue is covered

with a yellowish fur, and there may be nausea or sickness. The breath has an odour recalling that of chloroform or russet apples.

Acute grastro-enteritis is almost always accompanied by sleeplessness and restlessness, and the little sufferer becomes captious and irritable. These symptoms may last for ten days or a fortnight when, under suitable treatment and hygiene, the fever subsides, the appetite returns, the diarrhœa diminishes and little by little things return to normal, though the infant remains weak and ailing for some days because, be the attack ever so mild, it always causes great loss of weight.

The grave forms of gastro-enteritis are only met with during the summer heats, and attack principally debile, ill-nourished infants. It commences much in the same way as the mild form, but very soon displays points of difference. The temperature may run up to 104° F., the urine becomes scanty, the stools more frequent (15 or 20 in the 24 hours), they soon become brownish and extremely offensive, sometimes greenish and acid, sometimes colourless and exhaling a musty odour. In the last case the attack often assumes the form of infantile cholera. The motions are acrid and irritating, so that in spite of every care the buttocks and lower limbs become covered with erythema, the skin is excoriated, and we get superficial ulceration over the heels, ankles and buttocks. The infant may be reduced to a state of extraordinary weakness within a few days, the muscles become flabby, the eyes appear much larger than usual, and are surrounded by dark circles. Finally, convulsions and pseudo-meningitic symptoms supervene.

What then is the proper course to pursue when a child presents diarrhea? The medicinal treatment varies according to circumstances. Laxatives are indicated at the onset when the diarrhea is accompanied by fœtid flatulence and undigested food. Small repeated doses of castor oil may be given for four or five days, and this may be associated with equal parts of syrup of gum. The daily dose of castor oil need not exceed min. xv. under six months of age, and min. xl. under twelve months. After six months it may advantageously be given in the following form:—

Syrup of manna Syrup of gum Castor oil

Small doses of calomel (gr. 2 or 3) have been recommended, but this drug is not desirable under six months of age.

Opiates are indicated after the first few days if the stools are very frequent and liquid, and if the evacuations are accompanied by a good deal of pain. Needless to remark that when we give opium we must closely watch its effects, so that it is best administered in small, divided doses at frequent intervals. The daily dose should not exceed min. xii. of laudanum.

Subnitrate of bismuth may be given in doses of from gr. 15 to 30 daily to combat copious, refractory diarrhœa. Lactic acid has been recommended in green diarrhoa of very young infants, and yields good results.

Lastly, intestinal irrigation has been advised in acute enteritis, injecting some three-quarters of a pint or more of boiled water containing per cent. of chloride of sodium. These injections are of great service, repeated once or twice a day, when the enteritis mainly affects the large intestine. They allay the colic and fætid evacuations and they are quite unobjectionable and easy

Whatever medicinal treatment be adopted the most important thing after all in dealing with infantile gastro-enteritis is the prophylactic treat-

In presence of an attack of acute gastro-enteritis the first indication is to place the child on water diet. This means suppressing food of every kind for from twenty-four to thirty-six hours, giving only boiled water. After the water diet we have to feed up the little patient, and here the difficulties begin. Milk, however prepared, boiled, raw, sterilised, pure, diluted, and what not, may not be tolerated. Some success has attended the use of buttermilk or kephir. Sometimes these agree, sometimes not, it is a question of time, environment and individual idiosyncrasy. The best thing, perhaps, is to go back to the vegetable infusions so much in favour with our forefathers, so after the period of water diet the infant should be given a decoction of rice or pearl barley. Barley water is made as follows:-

Put a tablespoonful of pearl barley in a pint of water, boil for twenty minutes, and pass through a hair sieve. Then add sufficient boiled water to make a pint. Keep in a bottle that has been scalded and close with a cork that has been boiled. Decoction of oats is made in the same way

Decoction of cereals may be prepared as follows: take a tablespoonful of wheat, rye, oats, barley, maize and bran. Lightly heat in the oven or on an iron plate, then grind in a coffee mill or rub down to a pulp in a mortar. Stir up with a quart of water, boil and evaporate to about half its bulk (it must boil for at least two hours). Pass through a hair sieve and add water enough to make up a quart. To be kept in a bottle that has been scalded.

Dr. Comby's vegetable decoction is also extensively employed :-Wheat, pearl barley, crushed maize, dry white haricot beans, dried peas, lentils; an ounce (or one tablespoonful) of each. To be boiled for three hours in three quarts of water, to be passed through a sieve, add a little salt (dr. 5 of kitchen salt). There remains about a quart of liquid, which is sufficient for the day's use, and it may be thickened, when given, with a teaspoonful of rice, flour, barley meal, oats or wheat for every four ounces of the decoction.
All such decoctions must be freshly prepared,

in fact, it is best to prepare them day by day. They readily undergo fermentation, so that it is undesirable to keep them more than twenty-

Tisanes " of vegetables are also much employed. The formula recommended by Dr. Remy is the following:-

Carrots, oz. iss. Potato, oz. ii. Turnips, oz. ss.

Dry haricot beans jāā dr. iss. Dried peas Water, one quart.

These are boiled for four hours in a covered saucepan and then passed through a sieve. Add enough boiled water to make up the quart, together with 70 grains of salt. With this bouillon porridges can be made of rice, flour, potato meal or toasted bread.

The child can be fed on these vegetable decoctions for two or three days, but infants who cannot digest milk require something more substantial, and this is why the porridges are recommended.

Dried beer yeast has yielded excellent results in the treatment of infantile gastro-enteritis. yeast can be given in doses of about half a drachm in the twenty-four hours (Ed. or in the form of levurine extractive) mixed with sweetened water. In this form it is always well received by children, who are at the same time placed on water diet or other appropriate regimen. Under its influence the sickness promptly subsides, the stools become less fœtid and the constitutional symptoms abate.

It is when we begin to feed the child again that most care is required, for too sudden resumption of a milk diet is apt to be followed by relapse. For very young infants nothing equals human milk, failing this we may give milk diluted with boiled water or buttermilk, or we may try kephir made with skimmed milk or with ass's milk. Fortunately it is not often necessary to have recourse to these preparations, the child tolerating diluted milk after a stage of vegetable infusions.

After an attack of gastro-enteritis it is impossible to lay down precise rules for the resumption of We are fain to feel our way. In some cases we can give a tablespoonful every two hours or every hour, in others a teaspoonful every halfhour. All we can do is to try what the little patient can tolerate. In another twenty-four or thirty-six hours we may venture to go a step farther, and increase the quantities. It is unquestionably better to alternate the administration of milk with doses of rice water or vegetable infusion, which may also be mixed with the milk. For infants between two and four months of age we may give an ounce of milk with the same quantity of rice water, or vegetable infusion. quantities may also be doubled for infants between four and eight months, and may reach five to eight ounces for children between eight and fourteen months.

There are two excellent preparations which may be made use of, one alternately with milk, the other to mix with it, or to be given in lieu thereof for a time, viz., milk flour and malted flour.

The milk flour, provided it be fresh, is an excellent adjuvant. Half-a-teaspoonful is mix d with from two to four ounces of water, yielding a solution liquid enough to pass through the feeding bottle.

The malted flour is a cheap food, but requires some care in its preparation. Rice flour is made into a clear pap, two teaspoonsful of flour in a pint of water, for example, boil it gently, taking care to stir it all the time (a quarter of an hour). It is then sweetened and allowed to cool to 160°F. Some barley water is then added, which is prepared as follows:-Grind some malt in a coffee mill and put a teaspoonful of the flour in a tumbler of warm water (not exceeding 130° F.,

so as not to destroy the diastase). It is allowed to stand for a quarter of an hour. A tumbler of this water is mixed with the pint of sweetened rice pap, which soon becomes semi-liquid. This action is allowed to continue for twenty minutes, when it is filtered and used in the feeding bottle. This preparation is well liked by young infants, the dose to be according to age.

It is hardly necessary to remark that this mode of feeding must not be adopted to the exclusion of the others, but the malted pap is certainly the product which can be given for the longest time to the exclusion of milk (from four to eight

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by J. Jackson Clarke, F.R.C.S., Surgeon Royal National Orthopædic and Hampstead and N.W. London Hospitals. Subject: "The Clinical Examination of Spinal Cases."

#### ORIGINAL PAPERS.

#### PASSIVE HYPERÆMIA IN THE TREATMENT OF DISEASE.

By R. ATKINSON STONEY, F.R.C.S.I., Visiting Surgeon to the Royal City of Dublin Hospital.

In the summer of 1906 I spent about three weeks in Bonn, attending the hospitals where Prof. Bier was working. While there I had the opportunity of seeing large numbers of cases which were undergoing treatment daily by various forms of hyperæmia, and other cases which had been cured by this method of treatment. I was so impressed by the results which were being gained there that, before leaving, I obtained some of the appliances used and brought them back to Dublin. Since then they have been extensively used at the Royal City of Dublin Hospital, and it is the general impressions which I have gained from their use during the last two and a-half years that I wish to bring forward, without going into the very vexed question as to the exact manner in which hyperæmia brings about its curative results.

There are two main forms of hyperæmia, active and passive. Active hyperæmia is caused by the applica-tion of heat. This form of hyperæmia I do not intend to discuss, but shall confine my remarks to the second, or passive form of hyperæmia. There are two principal methods of producing this kind of hyperæmia—by the elastic bandage and by cupping or suction glasses. It was for the treatment of tubercular disease that this passive hyperæmia was first introduced more than 16 years ago by Bier, but of recent years its use has been extended to the cure of other forms of inflammation, both acute and chronic, and, curious to say, it would appear that good results follow more certainly and quickly the use of this treatment, not in the tubercular cases for which it was first suggested, but in the cases of inflammation due to other causes.

Bier himself explains that he got the idea of applying passive hyperæmia for tuberculosis from the following observations made by the older physicians. Farre and Travers, in 1815, and Louis, in 1826, called attention to the frequent appearance of pulmonary stenosis in phthisis, explaining it by the pronounced anæmia of the lungs which this form of heart disease produces. The observations of those physicians have been confirmed without exception, so that Frerichs (1853) could pronounce the dictum: "Pul-Frerichs (1853) could pronounce the dictum: "Pulmonary tuberculosis, be the relation of this disease to tuberculosis what it may, is the usual end in diseases of the pulmonary artery." Conversely, Rokitansky (1838) maintained that diseases of the heart, accompanied by fulness of blood in the lungs, offered immunity against tuberculosis. In his own words:

"A relation of hypertrophy of the heart to tuberculous disease is shown by the result of numerous observations. Out of 143 cases (simple, eccentric, as well as concentric hypertrophy), I find in 15 cases there is now extinct tuberculosis of the lungs. In all other cases-persons of variable age, sex, occupations, etc. -there never was a tubercle, from which it can be concluded that both diseased conditions cannot exist at the same time in one and the same individual, and especially that in the presence of the named disease the heart no tuberculosis, especially pulmonary berculosis, can develop." The same immunity tuberculosis, can develop." against, tuberculosis Rokitansky ascribed to people with distortions of the spine, in whom, as is well with distortions of the spine, in whom, as is well known, pronounced stases develop in the circulation of the lungs. Rokitansky's observations have been repeatedly confirmed, but they also have been frequently attacked. And though the large majority of physicians who have expressed themselves on this subject do not allow his assertions to stand in the comprehensive way that he expressed them, nevertheless they acknowledge the correctness of the principle. less they acknowledge the correctness of the principle and admit a relative immunity of congestion of the lungs against tuberculosis. I shall say very little concerning the treatment of tuberculous cases by passive congestion, as my experience has been neither very extensive nor promising.

First, as regards the method of producing passive hyperamia, or venous congestion by means of the elastic bandage. This is the method that is most usually adopted for tuberculous cases, specially tuber-culous disease of joints; it is also used, however, for extensive inflammations of a septic nature, as for instance, osteo-myelitis in both the acute and chronic stage, cellulitis, inflammation of tendons and their sheaths, as onychia, acute and chronic arthritis, etc. The first general rule to be observed is that in tuberculous cases the bandage is applied for 1 to 2 hours daily, whereas in all other cases it is applied for two periods of 8 to 11 hours, or one period of 16 to 22 hours out of the 24. The bandage can be used to produce a passive hyperæmia of the extremities or of the head and neck; in the latter case a band of ordinary black elastic encircling the neck below the larynx is used. By a special modification in the technique, a passive hyperæmia of the shoulder-joint can be produced, but as yet there has been no satisfactory means found of producing this hyperæmia in the hip-joint. Considerable care must be exercised in the application of the bandage or grave injury may result. And it is probably to a large extent owing to improper application that unfavourable results have been so frequently reported as following this method of treat-ment. The bandage is to be applied with sufficient force to offer some resistance to the venous flow, but none to the arterial. The pulse therefore distal to the bandage should not be reduced in volume, and the limb should not become colder, but rather warmer than its fellow, and should be of a bright or dark red colour, not purplish. But one of the best criteria of whether the bandage is properly applied or not is the sensation of the patient. Passive congestion, by whatever method it is produced, should never cause pain; on the contrary, one of its most striking features and greatest advantages is that it relieves pain if present. The further from the seat of disease that the bandage is applied the better, as a rule; so that in disease of the hand or wrist the bandage should be placed on the upper arm. Again, the bandage should cover an extensive surface, and the position should be slightly changed from day to day to prevent the skin from becoming chafed; especially is this advisable where the bandage is left on for long periods. Sometimes in the case of very thin patients, or in those with an unusually thin skin, it is very hard to prevent some pain and chafing of the skin under the bandage, but by washing the skin with alcohol, and placing a layer of cotton wool between the bandage and the skin, much may be done to avoid this trouble.

From my personal experience of this method of treatment of tuberculous disease of joints, I cannot say that I have seen any good results, but I must at once confess that this is probably my fault, and not the fault of the method, as I have not had the most suit-

able cases in which to try it, and have never had the patience to continue the treatment for the necessary length of time. According to Bier, about nine months is the least time in which this method can be expected to produce a marked result or cure. I must say also that while in Bonn I saw several cases in which this method of treatment had brought about excellent results. Extensive cases of tuberculous arthritis with nun erous sinuses, which had healed and left a movable joint. Bier himself confesses that he has had the least satisfactory results in the case of the knee-joint, and that in the majority of cases operative treatment is better here, as even if a cure is obtained by passive congestion the joint is usually stiff and liable to become contracted, and therefore no better than if the treatment had been shortened by early operation. In the cases of tubercular disease of joints also, it is In the cases of tupercular disease of joints also, it is much more difficult to produce the right degree of congestion than in other affections, and there is a much greater danger of doing harm. If the hyperæmia employed is excessive, either in degree or duration, cold abscesses are liable to form and spread with amazing rapidity. But in other pathological condi-tions I have obtained most gratifying results. For instance, in the treatment of onychia the following two cases may be taken as typical examples of what may be expected.

CASE 1.—A girl, et. 13, was seen in the dispensary on Wednesday, April 28th, 1909, the middle finger of the right hand had been sore for three or four days, and so painful that the patient had scarcely slept at all for two nights, the whole finger was greatly swollen, suppuration was evident on the front of the terminal phalanx. An incision one centimetre long was made and a small quantity of pus was evacuated, a congestion bandage was put on the upper arm and a loose dressing applied to the finger. The bandage was removed after 10 hours, there was no pain, the patient slept all night; for the next four days the bandage was applied for 22 hours daily, there was no further discharge, the pain, stiffness and swelling all rapidly disappeared, and the finger was well within a week.

Case 2.—A girl, æt. 22, was seen in the dispensary, CASE 2.—A girl, æt. 22, was seen in the dispensary, with great pain, swelling, redness and tenderness at side of nail of left little finger; this condition had been present for some days, and the patient had not slept the night before owing to the pain. There were no distinct signs of pus present. The bandage was applied to the upper arm for 22 hours on three consecutive days, pain and applied to the upper arm for 22 hours on three consecutives. secutive days, pain and swelling rapidly disappeared, and the finger had returned to its normal condition when seen on the fourth day. Instances like these might be multiplied indefinitely. As examples of might be multiplied indefinitely. As examples of cases of bone infection treated by this method, the following two cases may be quoted:-

CASE 3.—A young man, æt. 22, was admitted to the hospital in February, 1907; there was considerable swelling of the lower part of the left thigh, a sinus was present on the inner side, where an abscess had been opened in the country a month previously. On probing, an extensive surface of bare bone on the back and inner surface of the lower end of the femur was felt. An X-ray photograph showed widespread disease of the bone. An operation was performed and the bone freely exposed, and an opening made into its interior. There was no sequestrum, but a very large part of the lower end of the femur, including the whole of the popliteal surface was bare and rough. Both the elastic bandage and a suction glass were used in the after-treatment, and the parts healed up and the patient left the hospital apparently cured at the end of eight weeks. In May, 1908, the patient returned with a small sinus discharging thin purulent material in the track of the old scar, there was some swelling also of the lower part of the thigh. The bardage was again applied, and the sinus rapidly healed and the patient was discharged cured in three weeks. Since then he has remained well, and has been able to do all his ordinary work as a farmer.

CASE 4.—A man, æt. 32, was admitted to hospital on March 20th, 1909; he was sent up from the country for amputation of his foot. Six months previously he developed an abscess on the back of the leg just above the heel, this was opened, but the inflammation spread. When admitted the whole region of the ankle was

enormously swollen, numerous sinuses were present on the back, front and inner side of the ankle, bare bone could be felt on probing these various sinuses, and a probe could be passed apparently through the lower end of the tibia from one opening to another. There was also complete ankylosis of the ankle-joint, as shown by an X-ray photograph; this also showed great enlargement of the lower end of the tibia, with great enlargement of the lower end of the tola, with a cavity in the interior. The parts were thoroughly opened up and the cavity in the bone scraped; no definite sequestrum was found. The bandage has been used almost daily since a few days after the operation. The pain, which before and for the first few days after operation was excessive and prevented the patient from sleeping, disappeared immediately on the application of the bandage, and the swelling has almost entirely subsided, the sinuses are nearly all closed, and the patient will soon be able to leave hospital and return to his work.

It is, however, in cases of gonorrhœal arthritis, perhaps, that the most striking results are seen, the pain and stiffness disappearing with really marvellous rapidity. I have not had an opportunity of treating any of these cases in this way, but I had the opportunity of seeing some while at Bonn. One case specially impressed me, a man with acute gonorrhœal arthritis of his wrist. He assured me that the pain, which had been extreme, disappeared entirely within half an hour after the application of the bandage, and he was able to move the wrist to a slight extent without pain, while the bandage was in position.

Let us now pass to the consideration of the second great method of producing passive hyperæmia—that is, by means of cupping or suction-glasses. These are made in all shapes and sizes, from very large ones, which will cover a secreting mammary gland, to a very small one, which will just cover a boil. A partial vacuum is produced in the smaller ones by a rubber ball attached to them, and in the larger ones by means of an exhausting pump. This method is applicable to all cases of localised inflammation whether acute or chronic, specially to those where there is an opening in the tissues. The general method of use is to apply the cup daily for 45 minutes. During the scance the treatment is arranged approximately thus: the glass is allowed to remain in position for five minutes, and is then removed for three minutes; this sequence of events is repeated from six to eight times. Here again the same care must be taken that an excessive hyperæmia is not produced. The part within the glass should not become a dark purple, but a bright red, and no pain should be caused. If there is pain the glass is improperly applied. Of course, strict asepsis should be observed, the glass being boiled before use, and the surrounding tissues cleaned. It is well also to smear the skin in the neighbourhood of a sinus with some antiseptic ointment (personally I use one composed of equal parts of tinct. benz. co. and vaseline), to prevent irritation of the skin by the discharges and to assist the glass in adhering to the part. A glass of a sufficiently large size to include a fairly broad area of tissue around the opening should always be chosen, as otherwise a strangulation of the parts may be produced, or the edges of the opening may be pressed together and the discharges prevented from, rather than assisted in, escaping. In some cases, especially where there is a long sinus leading to an extensive cavity, it may be advisable to place a drainage tube in the opening before applying the cup. In the cases of tubercular sinuses and abscesses, the degree of vacuum produced may be somewhat greater, and the duration of application may, with advantage, be somewhat longer than in cases of acute septic in-flammation. With the assistance of this method of treatment, it will be found that boils, carbuncles, abscesses, tubercular sinuses, etc., will heal with greatly increased rapidity. The following case is fairly typical of what may be expected.

CASE 5.—A boy, æt. 16, was admitted to hospital in March, 1909, with a large acute abscess on the back of his neck. A small incision was made, and about 1½ oz. of pus evacuated. A cup was applied on three successive days. The discharge rapidly decreased, and the patient was sent out cured on the fifth day.

In abscesses of the breast it is, perhaps, that the most gratifying results are seen, for by means of a very small incision, followed by the application of a cup, even severe cases may be cured in a short time without extensive scarring, deformity, or loss of function. My personal experience of the treatment of this class of disease has been limited to a few cases. Bier says that he has seen excellent recoveries where he has had to open as many as eight to ten abscesses successively by separate small incision. In puerperal mastitis it is generally advisable to use a large cup which will include the whole breast, and many of these cases will recover under this treatment without advancing to the stage of suppuration. In other cases, where a definite abscess has formed, especially if it is superficially placed, it is often better to apply a smaller cup to the involved portion of the breast.

It must always be distinctly understood that this method of treatment by passive congestion is not intended to replace or do away with the general principles of surgery, or that by its use operative measures can be abandoned. The rule of surgery still holds good: when pus is present it must be evacuated at the earliest opportunity. But with its help a smaller incision may be used, and tedious after-treatment and drainage may be greatly reduced or done away with.

This method of treatment of abscesses with suction is by no means a new or recent invention, as Nicolaus Florentinus speaks of the treatment of buboes in the following terms:—"Extractio puris cum incisione et suctione—i.e., cum ventosis et cum eis, qui trahunt pus post sectionem et apertionem." Also in some parts of Southern Russia women afflicted with mastitis, at the very beginning of the disease, place over the glands large pots, in which some kerosene has been ignited, and they are apparently convinced of the effectiveness of these large cupping appliances. Bier himself employed cupping glasses and suction apparatus for the purpose of producing hyperæmia for acute inflammation, many years ago, when he was in Kiel and Greifswald, but only for the treatment of furuncle. His intention was not only to produce hyperæmia, but also to suck out with the rarefied air the pus and necrotic shreds, and in this he succeeded. Tilman especially, at his instigation, made extensive experiments in this direction at the Greifswald Polyclinic, but he was not altogether satisfied with the results. He found the appliances too painful for the patients, and the hyperæmia produced altogether too energetic, and herein lies the cause of failure of these early attempts. Of late, however, Klapp, Bier's chief assistant at Bonn, has resumed the treatment in the Bonn Polyclinic, and has extended it to all possible forms of inflammation and suppuration, and has so fully developed the technique that he can show most excellent results.

Space does not permit me to write further of the numerous classes of cases to which treatment by passive hyperæmia is applicable; as the neck bandage for various affections of the head, otitis media, mastoiditis, boils, carbuncles, diffuse acne, etc.; or the use of glasses for tubercular glands, both before and after softening and suppuration; or the treatment of empyema by suction glasses, from which I have had some good results. The various pathological conditions in which passive hyperæmia is being used are continuously on the increase, but in many of them further experience is necessary before it can be definitely stated how much is to be expected from this method of treatment, and here there is a large field open to anyone who is sufficiently interested to undertake investigations on his own account. But it may be asked, cannot congestion hyperæmia do harm? specially in cases of acute inflammation, which in itself frequently leads to grave circulatory disturb-Personally, I have only seen harm done in one case, where a cup was applied over a large carbuncle on the top of an infant's head; after the first day the application of the cup was entrusted to the nurse, and on seeing the case a few days afterwards, I found that an area of skin corresponding to the size of the cup used was gangrenous; this was due not to the treatment itself, but to the way in which the treatment

was carried out, as the cup had been put on with somuch pressure that the tissues were compressed between the rim of the cup and the skull. cases where the glasses are placed over superficial bones or dense, firm membranes, special care must be taken to prevent this strangulation of the superficial tissues. This accident occurred during the first six months after the introduction of this treatment, and since then I have seen no other bad result. In the first edition of his book Bier says: "I am convinced that the greatest mischief can be produced with the remedy in progressed cases of phlegmon of the soft parts. The circulatory disturbance in such cases is so pronounced that gangrene of the attached parts is threatening. And in these cases the removal of the congestion is indicated, and not an increase of the latter? He has however modified his views. the latter." He has, however, modified his views, and in the last edition of his work says: "I admit that there is such a variety of inflammation, but it is extremely rare, and it is not the circulatory disturbance, but the producer of inflammation (essentially bacterial toxins) which kills the tissues. advisable, especially for such physicians as are little experienced in the method, to abstain from the application of congestion hyperæmia in inflammation considerable congestion. At any rate, in such inflammation, whatever abscesses may be present, should be thoroughly incised. To this, however, must be added that in all cases of acute progressed suppuration which I have treated with congestion hyperæmia I have not seen a single case where the agent produced real or lasting harm, and but one in which it was not tolerated on the extremities. Correctly applied, congestion hyperæmia does not mean disturbance, but improvement of nutrition."

# CASE OF BANTI'S DISEASE, WITH PULMONARY PHTHISIS AND HERPES — DEATH FROM HÆMORRHAGE.

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THE following case is of interest, partly on account of the rarity of the disease itself, and partly on account of its course and complications. P. came under my care in the beginning of August, 1902, suffering from severe metrorrhagia. She was 46 years of age, married, and the mother of a family of four sons and one daughter, the eldest being 21, and the youngest, the daughter, 7 years. All are healthy, but there were some mishaps between the boys and the girl. No history of syphilis could be obtained either in herself or in herhusband. The lungs and kidneys were healthy, and there was a slight systolic blowing over the apex of the heart. This I thought might have apex of the heart. This I thought might have been due to the secondary anæmia. The pulse-rate was not greatly increased, nor was there any rise of temperature.

The hæmorrhage persisted for about six weeks, with brief periods of cessation, in spite of absolute rest in bed, with elevation of pelvis, and large doses of ergot, opium, and other hæmostatics and sedatives. The blood came in large clots, for which examination per vaginam revealed no evident cause. It was noted at this time that the spleen was enlarged and hard, the notch being quite palpable, and that the tumour reached the pubisand crossed the middle line, but, in view of the severe bleeding and the critical condition of the patient, no minute external examination was made. There were no enlarged lymphatic glands anywhere. No ascites were noted. The colour and consistency

of the blood-clots were at first normal. The patient latterly became extremely pale, with a slightly yellow tinge which I attributed to the loss of blood. She recovered from this illness sufficiently to be able to be up and attend to her household duties.

About the end of September I spoke to her about the possibility of removing the tumour. At that time the microscopic examination of the blood showed no relative increase of leucocytes, nor other marked alteration beyond that explicable by the secondary anæmia, and as the tumour was causing her no immediate inconvenience, she preferred to leave it alone. I explained to her that I might be unable to remove it later, as another hæmorrhage might leave her much weaker than she then was.

In January, 1903, she suffered from a left pleurisy, and was confined to bed for a period of four weeks. Then followed several severe attacks of epistaxis, but no other serious illness. I had been seeing several other members of the family for trivial ailments, and consequently Mrs. P. was under almost continuous observation from her first illness in August, 1902, until her death in September, 1903. She was always complaining of feeling weak, and she seemed to be working beyond her strength. In the beginning of May, 1903, when I called one day as usual to see her husband who was then ill, I found Mrs. P. suffering from severe abdominal pain. I had spoken to her on a recent visit about having the spleen removed, and she had so far consented that I had arranged a consultation later in the day with a colleague to discuss splenectomy. She was attending to her ordinary duties, and I sent her to bed and carefully examined the abdomen. Over the lower end of the enlarged spleen, and extending down to the pelvis, was a long flat tumour 8 inches by 5 inches, and fluctuating. There was no discoloration of the skin. 1

My diagnosed a rupture of the enlarged spleen. colleague agreed with me when he saw her later the same day in consultation, and on aspiration, pure blood was withdrawn. Next day and the whole week following there was a good deal of discoloration of the skin over the tumour, which proved it to be an extensive subcutaneous hæmorrhage. If it had come from the spleen, as I originally supposed, it must have been entirely shut in by adhesions, and superficial discoloration would not have appeared. This swelling gradually became absorbed during the next fortnight and the discoloration also had almost vanished. Some little fluid remained, but was not in large amount and occupied the region previously occupied by the tumour.

About the end of May she developed a slight cough, with temperature running up to 101° and 102° at nights, and this cough persisted to the end, with but little improvement at any time. right apex became dull on percussion, and later a few small cavities were detected. Breathing became very difficult, and by the middle of June she looked moribund. There was a good deal of ascites and dropsy. Diarrhœa ensued with bloody stools, and the ascites decreased. Respiration again improved, and she was soon back to her normal, though feeble, condition. But the skin and conjunctivæ were now distinctly jaundiced and the urine was of a deep brown colour. The urine began to get clearer after three or four days, but she never got out of bed again from June onwards. She had repeatedly slight bilious attacks, a persistent rise of temperature (100° to 103°), and occasional hæmorrhages from the bowel. She occasional hæmorrhages from the bowel. rarely slept, and was very restless at night. On August 11th she complained of severe headache, confined to the right half of the brow and head,

and running back to the line of the ear. The pain was specially severe over the right eye. I gave her 10 grs. of phenacetin, and some menthol ointment to apply locally. Next day she was worse and the pain agonising, and the painful area was all red and swollen like erysipelas. On the third day, August 13th, a herpetic rash appeared, but still the pain was severe, and she required morphia to quieten it. The swelling gradually subsided, and the whole patch became gangrenous. On August 29th hæmorrhage commenced from the lower edge of the slough, and was so severe and persistent that I had to ligature both the anterior frontal branch of the temporal and the supra-orbital arteries. Even then the oozing was pretty bad, but hot water applications, with pressure, finally stopped it. Granulations grew fairly rapidly and the danger of bleeding seemed over, when, on September 10th, she began to vomit. At first blood alone came, and then a brownish fluid mixed with bilious matter. Bleeding recommenced in one of the granulation areas in the forehead. This bleeding and the vomiting continued for most of the day, the vomit in the end being foul and stercoraceous, and she gradually collapsed, became comatose, and died the same evening.

This is the worst eruption of herpes I have ever seen, both as regards the pain complained of and the complete destruction of the affected skin, which extended from the middle line right back to the ear, and from the supra-orbital border to the

hairy scalp.

It may be argued that this is not a true case of Banti's disease, and there is wanting post-morten and microscopic confirmation. blood examination is not so minute nor so accurately detailed as has been the custom in recent blood examinations, but it was sufficient to negative leucocythæmia, and to suggest to me at the time the possibility of bettering the condition of my patient by a splenectomy. The later symptoms—during which there is no record of a blood examination in my notes-viz., repeated hæmorrhages, jaundice, and gastro-intestinal troubles, made it evident to me that I was probably dealing with a case of Banti's disease, as distinct from simple splenomegaly or splenic anæmia. The condition of the patient was, however, then always so poor and uncertain that I did not have sufficient confidence in splenectomy to advocate it to the exclusion of all other treatment. Less than a score of cases of removal of the spleen in Banti's disease, with a mortality of nearly 30 per cent., had been at that time recorded (1), and it was not until I felt how helpless the physician is when face to face with such a case, that I ventured again to suggest splenectomy, and to call in a colleague to strengthen my position. Unfortunately, severe hæmorrhage, with the low condition of the patient, made us hesitate, and no sufficiently satisfactory period occurred later to make me again wish to undertake the risk. It was difficult to erase from one's mind the huge mortality that had followed splenectomy in the past, and it was not until the surgical mortality for the different forms of splenic enlargement had been worked out (2) that one's confidence in the operation was in some measure restored. For leucocythæmic enlargement the mortality in 1903 stood at 96 per cent., for ordinary splenomegaly and splenic anæmia at 37 per cent., and for Banti's disease at 28 per cent. Armstrong (3) in 1906 brings the record up to thirty-two cases with a mortality of 28 per cent., and, where the after-histories could be traced, with almost perfect restoration to health in every case. Johnston (4) in 1908 collected sixty-one cases with a

mortality of 20 per cent. over all, though in the last forty-four cases there were only seven deaths. The immediate mortality, as one would anticipate, was due to hæmorrhage, some of the cases leaving the operating table with tamponage, after ligature had failed. The operation itself, apart from this liability to hæmorrhage, is not deterrent in its magnitude, and, where no adhesions or ascites are present, should show a very small immediate mortality. Ascites, in addition to the usual syndrome, makes operation much more serious, as there would seem at first sight to be little use of removing the spleen and leaving the abdominal cavity to quickly refill with fluid from the liver complications. Tansini has twice, in addition to removing the spleen, done a Talma or Drummond-Morrison operation, where a new circulatory anastomosis is effected by union of liver and omentum to parietal peritoneum, and at least two other surgeons have operated similarly, and while this seems a necessary adjunct to splenectomy in severe ascites, it yet makes one hesitate in frail patients to recommend operation. At no stage in my own case would I have felt justified in suggesting both operations. Nor do I think that the liver would have caused trouble in my case, as the enlargement of the liver was never noticeable, nor was there any ascites except just before the diarrhœa, and it did not recur. That the liver was affected is shown by the jaundice, which was well marked on one occasion, and the yellow tinge, which was never absent during the last eight months, was very suggestive of cirrhosis of the liver. In a number of the cases where splenectomy alone was done, the cirrhosis and ascites have improved pari passu with the improvement in the blood condition, and where the hæmorrhage is a danger it would be madness to attempt hepatopexy-itself a bloody operation—when there is a likelihood of a perfect cure resulting from it.

The terrible anæmia, the constant cough, the cavitation of the apex of the lung, and the difficulty of stopping even the slightest bleeding, were all additional and serious contra-indications in my case. Still I cannot help feeling now that I missed an opportunity for interfering surgically, which would have been at the time I first mentioned splenectomy to my patient. But I then had not sufficient confidence in splenectomy, and I mistook the significance of the metrorrhagia, putting it down as a not unusual occurrence in women nearing the menopause. It was the other hæmorrhages that made me diagnose Banti's disease, and by that time my patient's condition was complicated by the pleurisy and other respiratory lesions. Splenectomy seems rather a too serious operation, and, with probable adhesions, a too difficult one. I could not, moreover, with so slight liver symptoms, give an absolutely hopeless prognosis, even with purely medical treatment, for some of the cases recorded were very chronic (5). Gaucher's case, for instance, lived twenty-five years after enlargement of the spleen was noted. On the other hand, hæmorrhage is so intractable at times that only a few days after discovery of the splenomegaly the patient may die of intestinal hæmorrhage. Such a case is recorded

by Murrell (5).

The ætiology of the disease is still obscure.

The microbic theory, and the There is the inevitable microbic theory, and the hectic temperature certainly suggests a septicæmia condition. In my own case the high temperature seemed to be due to the lung complications, which were so evidently phthisical that I did not trouble to even get the sputum tested bacteriologically. Most writers (6) seem to incline to an intestinal infection as the causa causan. here has been no specific

germ isolated from the alimentary tract, the blood, or the spleen.

What specially determined the herpes is also obscure. She was in bed at the time, and one could hardly suggest the handy "chill." The usuallydescribed inflammatory changes in the central nerve ganglion might have been set up by some septic thrombosis lodging in or near the Gasserian area.

The treatment seems to be in all these cases so far purely surgical, and, once diagnosed, there is no excuse for delay. All the cases medically treated have ended fatally, some of them very speedily, and the mortality of splenectomy will diminish rapidly when these cases are handed over to a surgeon in their earlier stage.

Atherton (3) quotes a case where great benefit followed exposure to X-rays, and he suggests this treatment in all cases prior to splenectomy, and when the patient is too weak for surgical treatment.

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#### FLEAS AS TRANSMITTERS OF PLAGUE. (a)

By Professor SHIGA, M.D.

SINCE the discovery of the plague bacillus, suggestions have been made to the effect that certain insects, especially fleas, may serve as the transmitters of the germ. The final demonstration that the rat fleas play a most important part in the epidemiology of plague has been shown by the systematic investigation of the Indian Plague Commission, while Liston has proved conclusively that the common Indian rat flea (pulex cheopis) is the essential agent in the transmission of plague. In Japan, it has been found that the fleas commonly infesting rats do not belong to pulex cheopis, but ct. musculi and cer. anisus. Further, the fleas are most prevalent in hot summer, while plague epidemics usually take place in the cooler season. Thus the non-coincidence of the season of prevalence in plague and fleas, does not favour the flea theory. My present work was planned in view of determining the still uncertain fauna of rat fleas in Japan, and at the same time to see how far they may play their part in the propagation of plague. The observation was made at Yura, where a plague epidemic broke out in 1908. the first step of the investigation concerning the part played by fleas in the epidemiology of plague, they were collected in Tokyo and its vicinity until the month of September, 1908, that is, just before the work was carried out in Yura. During the month of October, when plague thickly infested the town, 2,130 fleas were collected from several sources in Yura, and the result of the examination showed that pulex irritans was found on men, ct. felis on cats, and ct. canis on dogs exclusively, 551 were collected from house rats, which consisted mostly of the common Indian rat fleas. Pulex cheopis, i.e., 255 or 46 per cent., 239 or 90 per cent. were found to be the common Indian rat fleas. As many rats as could be obtained were examined in view of determining how many fleas a rat may harbour, and it was found that a healthy rat carried 2.2 fleas in average, while a plague rat carried 11.3. This wide difference between their numbers agrees with the reports from India and Sydney. In order to see the ratio of the number

<sup>(</sup>a) Read before the Plague Section of the Indian Medical Congress, Bombay, February, 1909.

OPERATING THEATRES.

of fleas in plague, and healthy houses, guinea pigs were let loose in several houses and their fleas were collected. In the experiment, 33 guinea-pigs were set free in 12 healthy houses and only collected 16 fleas, while 36 guinea-pigs were employed in the same number of plague houses, where 249 fleas were collected. The average number of fleas was found to be 20.7 in plague houses, while in healthy houses it was only 1.3. Again, if we average the number to one guinea-pig in each case, the former becomes 9.0 and the latter 0.4.

The Indian Rat Flea. Of the total of 249 fleas from the plague houses, 227 or 90.1 per cent. were identified to be the common Indian rat flea. Therefore, one thinks of the intimate relation existing between the prevalence of plague and this species of fleas. Again, out of the 207 collected from the plague houses by means of guinea-pigs, 49 were proved to carry bacteria, making the percentage of 23.6 and that of the common Indian rat fleas alone is 22.3. This disproportion between the percentage in the Indian rat fleas in both cases may be explained on the ground that the examination of the plague houses and of the 15 human fleas collected from the above observation was made only with the aid of the microscope, which is an imperfect means for deciding a matter of such great consequence. Therefore the culture and animal tests were made with the 43 rat fleas collected from the plague houses with the 15 human fleas collected from the beds of the patients. They proved most clearly the presence of the real virulent pest bacilli in every species of fleas. There is scarcely any doubt as to the possibility of transmission effected by rat fleas, and it is a noteworthy fact that in Japan as well as in India, pulex cheopis plays an important rôle in the plague epidemics. My observation in Japan reaches no further than the confirmation of the infallibility of the result of the elaborated investigation effected by the Indian Plague Commission. Though small in number, the presence of the pulex cheopis provides all the necessary conditions to the spread of plague, and when the germ is introduced into such a place it will produce an epizootic among the rat family. I have been entertaining the view that in Japan plague has been introduced from abroad. It is still more confirmed by the present investigation, which showed that the unwelcome guest, pulex cheopis is continually flowing in at our sea As has been suggested by me, the only means by which we may save mankind from this scourge of plague would seem to consist in routing the evil at its very source, and the international conference on plague will probably afford us all the best possible chance of solving the plague problem.

The Bombay Medical Congress bears an inter-

more frequently. It is announced that a deputation, representing all the London hospitals and the various charitable institutions of the country, will wait upon the Chancellor of the Exchequer to ask for relief from certain proposals of the Finance Bill. It has been pointed out, in a memorandum sent to Mr. Lloyd George, that the hospitals and the other charities are doing a voluntary work of national importance, and that they are, therefore, entitled to relief. At the present time these bodies are exempt from the payment of income-tax upon their invested funds, and it is suggested that whatever the form in which the proposals of the Finance Bill are ultimately passed, a similar exemption should be granted in the case of bequests to charities or land transactions carried out by them.

national character, for it has been planned on a

large scale covering nearly all the leading countries in the Far East, and it is my sincere wish to encourage the holding of this kind of congress

GREAT NORTHERN HOSPITAL. Excision of the Astragalus.-Mr.

EDMUNDS operated on a man, æt. 25, who had been admitted suffering from a tuberculous ankle. The onset of the disease had been insidious, and an abscess had formed and ruptured behind the internal malledus. There was swelling all round the ankle-joint, and at the spot where the abscess had ruptured the skin was infiltrated for about two square inches. The leg was wasted, and the patient's general health had begun to suffer. The question of treatment, Mr. Edmunds said, lay between an amputation and an attempt to remove the disease locally. In children, he thought, amputation is rarely necessary, but in adults the objections to it are largely sentimental. Conservative surgery, however, should always be attempted unless there is grave tuberculous disease elsewhere, for example, in the lungs, in which case tuberculosis of the ankle-joint is probably treated better by amputation. In the present case, although the condition was severe, it was better, he considered, to make an attempt to save the foot than to amputate immediately; nevertheless, at the present time it was by no means certain that this procedure might not become necessary.

An incision was made round the opening of the sinus, which was surrounded by the infected skin, the incision being extended upwards and downwards; a similar incision was made on the other side of the ankle. The joint was then thoroughly exposed and the astragalus with the synovial membrane completely removed (the synovial membrane was that of the anklejoint and of the adjacent joints). The disease had infiltrated the tendons at the back of the internal malleolus, and it was necessary to remove these. The wound was closed, a drain being left in for 24 hours, and the limb put on a rectangular splint. No septic complications ensued, but both incisions became the seat of a slow growing form of tubercle. On a second occasion the patient was anæsthetised and the affected spots in the incisions thoroughly curetted. The ordinary angular splint was found uncomfortable, therefore the foot was enclosed in a pair of splints made of ordinary wire netting; a material which, as Mr. Edmunds pointed out, can be moulded readily and which is light and easily sterilisable.

Mr. Edmunds said that excision of the ankle, in the

strict sense of the word, is a bad operation, because an operation exactly comparable to that performed at the knee-joint would give a poor access to the synovial membrane, and in consequence little chance of removing the disease. Removal of the astragalus, however, afforded quite a thorough access to the joint, and the resulting foot is quite useful; indeed, in little children the loss of the bone can only be detected by careful examination.

The wound was much benefited by the scraping and looks as if it would be healed very shortly. When this is accomplished it is proposed to supply the patient with a peg-leg, so as to enable him to get about without putting his foot to the ground. Six months would have to elapse, Mr. Edmunds said, before putting the foot to the ground.

#### TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

MEETING HELD JUNE 10TH, 1909.

The President, Dr. HERBERT SPENCER, in the Chair.

A SHORT communication was read by Mr. J. BLAND-SUTTON on

RED DEGENERATION OF A UTERINE FIBROID associated with the staphylococcus pyogenes aureus. The patient, a primi-gravida, when two months advanced in pregnancy, was seized with an acute and

sudden abdominal pain. At the operation performed 24 hours later the patient was found to have a large subserous fibroid and several interstitial ones. Hysterectomy was performed and the tumours carefully examined by Mr. Somerville Hastings. The larger fibroid amined by Mr. Somervine riastings. The larger motors presented an area of softening, and the surface over this area was covered with lymph. From this "infarcted area" a pure culture of staphylococcus pyogenes aureus was obtained. No micro-organisms were detected in the interstitual fibroids, although they exhibited the red change in streaks.

Mr. G. F. DARWALL-SMITH read a short communication on

#### AN UNUSUAL SOLID TUMOUR OF THE OVARY.

The patient from whom the tumour was removed was a multiparous woman, et. 36. She was found to have a rounded, solid tumour in the right posterior quarter of the pelvis the size of a man's fist. This was removed, and on examination the tissue of the ovary could be seen to be stretched as a capsule over the substance of the tumour proper. The cut surface of the tumour looked like an ovarian fibroma. On microscopical examination, scattered about in the fibrous stroma were seen strands of cells resembling those of glandular epithelium. Some of these cells showed degenerative changes. The diagnosis seemed to lie between endothelioma and adenofibroma.

Dr. W. S. A. GRIFFITH mentioned that he had removed a similar tumour of the right ovary with similar microscopical characters. The tumour showed clinically no signs of malignancy.

A short communication by Dr. KEDARNATH DAS on

FŒTAL CHONDRO-DYSTROPHIA

as a cause of brow presentation and dystocia was read, and notes of two cases of this condition were given.

Dr. J. S. FAIRBAIRN read a paper on

PRIMARY CHORION-EPITHELIOMA OF THE OVARY.

The paper was based on the case of a woman who had had four pregnancies, the last in February, 1905, when the placenta was removed by hand, and the convalescence was protracted. For some months before admission to St. Thomas's Hospital there had been slight, but continuous, uterine hæmorrhage, and for about six weeks abdominal pain, chiefly on the right side. A tender swelling in the abdomen had been noticed by the patient for about three weeks and was the reason for her seeking advice. This was thought on examination to be an ovarian cyst with torsion of the pedicle, but at the operation on January 3rd, 1907, it was found to be a hæmorrhagic tumour of the left ovary with extensive adhesions, but no twisting of the pedicle. It was removed, and also the right ovary, which was cystic and involved in adhesions. The patient showed no signs of recurrence two years after

The tumour was of the size of a small cocoa-nut. It was covered with a white capsule of tunica albuginea, and on section was found to be made up of a mass of hæmorrhagic tissue. Microscopically, the main part of the tumour consisted of blood-clot, fibrin and necrotic tissue, but under the capsule, between the ovarian tissue and the mass of clot were seen the typical syncytial masses with small polyhedral cells of chorion-epitheliomatous growths. No traces of tera-tomatous elements were found. There was no history to indicate anything of the nature of a cystic mole or of chorion-epithelioma elsewhere, and this was taken as sufficient evidence that the growth was solely and primarily one affecting the left ovary.

Other cases of primary chorion-epithelioma in the ovary were discussed. Seven collected by Pick, and others by Michel, Schmaus and Kleinhans were mentioned, but particular attention was directed to two from Doederlein's klinik which occurred in multiparæ, and appeared to be very similar to the one described. Three possible explanations of the origin of chorionepithelioma primary in the ovary offer themselves. (1) It may arise as in Pick's cases and as in chorionepithelioma in the testicle, from teratomatous elements; (2) it may arise from a preceding ovarian pregnancy, and (3) it may be due to transportation of villi from a preceding pregnancy, molar or otherwise. The present case and Doederlein's two were considered as in a class by themselves and as differing from Pick's in that his series included many younger patients (ages 9, 16, 17, 21, 24, 30 and 36), that all except one were nulliparæ, and that there was more definite evidence of a teratomatous origin in the mixed nature of the tumour elements and in the extreme malignancy of the growths. Any further discussion as to the origin of such primary growths must be purely speculative, but as suggesting a possible origin from transported villi, attention was directed to the fact that in two of the three cases specially considered, it was found necessary to remove the placenta manually in the labour immediately preceding the illness.

Dr. Blair Bell read a paper on a case of RUDIMENTARY UTERUS DIDELPHYS.

with ectopia of each uterine body in an inguinal hernia sac, with some remarks on the development of the female genital organs.

The patient was a young woman, set. 20, who had had a double inguinal hernia all her life. Lately there had been attacks of abdominal pain, which caused her to seek advice.

The patient was found to be well-developed and telligent. She had never suffered from monthly intelligent. molimina.

The external genitals were normal in appearance and covered with hair. There was total absence of the vagina, but a circular fringe indicated the formation a hymen. Per rectum no pelvic genital organs could be detected.

At the operation a central sub-umbilical incision was first made in order to investigate the state of affairs. There was a smooth and uninterrupted vesico-rectal Above the true pelvis on either side there was a large hernial orifice. Protruding down the right aperture was the Fallopian tube and ovary; on the left side only the fimbriated extremity of the tube was visible. An incision was next made over the left inguinal canal, and the hernial sac-together with the left uterine body, which was firmly incorporated with it, and the Fallopian tube and ovary—was removed, and a radical cure effected. On the right side the hernial sac and the uterine body were separated from the Fallopian tube and ovary and removed, a radical cure of the hernia being then carried out. The patient made an uninterrupted recovery. On histological examination the left ovary was found to be functional.

The conditions of uterus didelphys and hernia of the uterus were discussed and their relative importance The rarity of actual ectopia of uterine considered. bodies, such as was found in the case described, was mentioned, the only other similar cases on record being those of Roux and Werth. Finally, the "descent" and development of the genital organs was considered in so far as the malformation found in this and other cases seen and mentioned by the author were concerned. The conclusion arrived at was:

That uterus didelphys (and ectopia of the uterine bodies) is due to absence of fusion of the Mullerian ducts, caused by the deficient action of the decussating subperitoneal muscular fibres which normally form the external coat of the uterus; and also (especially when ectopia co-exists) by the deficient formation of uterosacral muscular fibres. As a contributory factor a short genital mesentery plays an important part.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, MAY 21ST, 1909.

The President, Dr. E. H. TWEEDY, in the Chair.

THE PRESIDENT exhibited specimens of

FIBROIDS, WITH RED DEGENERATION, removed six weeks after delivery. The woman had been sent to him six months pregnant, and with a large myoma. He kept her over two months in hospital. He induced labour at full term. The child was dead. On the third day her temperature and pulse rose, and on the fourth day the temperature reached 1030. There was great tenderness of the

abdomen, and he became very uneasy about the case. He asked Sir William Smyly to see her in consultation on the fifth day with a view to immediate opera-Sir William advised postponement of the operation, and the woman got gradually better. When her temperature became normal he removed the tumour by supra-vaginal hysterectomy. It showed in a very characteristic manner red degeneration, which was a disease that apparently very rarely occurred save in pregnancy. High temperature was a constant symptom of red degeneration; and this he thought might arise apart from a germ invasion, and be due to absorption of toxic matter found in the degenerating myoma.

Dr. Pureroy said the change noticed in one of these tumours was one of the least common forms of degeneration, and one of which they knew least. He was not quite convinced that the temperature was due to the red degeneration. He was inclined to think that it was connected with a certain degree of localised

sepsis.

Dr. Jellett said he was watching a patient who came to him six months pregnant with a large myoma below the fœtus, filling the pelvis. The patient had been going on very well since. In such a case, where there was a large myoma on the posterior wall of the uterus, filling the hollow of the sacrum, and in which the cervix was jammed above the symphysis, he would like to know how long Dr. Tweedy would allow her to remain in labour. Sometimes tumours that were firmly impacted did get drawn up, but in his case it seemed rather hopeless to expect the tumour to do so.

Dr. ROWLETTE said there were certain points about red degeneration which were fairly fixed. It was commonly found associated with pregnancy, and seldom in other conditions. In almost every myoma associated with pregnancy which he had seen there had been more or less red degeneration. It was certainly a necrotic change of some sort, as the tissue failed to stain. In pregnancy the entire tissue of the uterus was in a highly vascular condition, and something interfering with the blood supply, causing stasis in the veins, might cause a diffusion of blood pigment. There was no doubt that in some cases the red degeneration might give rise to temperature, as it was liable to be affected by septic or putrefactive organisms.

The PRESIDENT, in reply, said the myoma was chiefly situated on the fundus, but also encroached on the lower uterine segment. It was only when he became convinced that the growth had undergone degeneration that he determined not to let her run the risk of another pregnancy. He thought Dr. Jellett's case was plain sailing. His patient should not be allowed even to fall into labour. He should calculate the time of full term, and perform Cæsarian section. After removing the child it would be easy to remove the uterus. The myoma was almost certain to the uterus. The myoma was almost certain to degenerate if she was allowed to fall into labour. He thought there was a toxin that could raise the temperature apart from germ invasion.

Dr. Purefoy read a paper on

SOME PATHOLOGICAL CONDITIONS OF THE URETHRA, which will be published in a future number. In the discussion that followed,

Dr. FitzGibbon recalled a case in which treatment consisted of passing a probe up the urethra, with some cotton wool on the end, and either an antiseptic or some form of caustic applied to the cavity, out of which from 20 minims to half a gram of pus could be squeezed. It gradually healed after three or four months, though he had no doubt that it would have been cured quicker if radical methods could have been

Dr. JELLETT said that he thought that, if possible, in cases of urethral cysts one should try to get away all traces of the cyst wall, and bring the mucous membrane over it, as by so doing there would be a better chance of a permanent result at one operation.

The President said the difficulty of dissecting out an abscess cavity without infecting the raw surface was very great, and he thought Dr. Purefoy's plan

was perfectly surgical. He had seen a condition that Dr. Purefoy spoke of incidentally, but he had not seen it described as an ulceration around the urethra that ran down towards the posterior fourchette. It was absolutely indolent, and occurred in elderly women. It was completely cured by incision, but no other remedy that he know of could cure it.

Dr. Purefox, in reply, said Dr. Jellett's method was theoretically the better one, but it was not always the best in practice. Howard Kelly treated such a case in the radical way, and had to deal with a fistula

afterwards.

Dr. Solomon read a paper founded on a case illustrating the

TOXEMIA OF PREGNANCY COMPLICATED BY RUPTURE OF THE UTERUS.

The President said he did not remember a case that bristled with so many points of interest as this one. How was it that in one case a dead foetus could lie in the uterus and not do any harm, whereas in another case the death of the fœtus was followed by severe toxic symptoms, and how was it that in eclampsia the feetal death was considered of favourable omen? The case was remarkable in that ascites arose as a consequence of the toxin, which he thought showed that the liver had been involved rather than the kidneys. The elucidation of such cases would require the services of a physiological chemist, and showed the deficiency in that respect of our hospitals. Dr. Solomon's case gave positive proof that there was a toxin present within the uterus, although the statement had never been accepted. There was a great future for the hospital that could spend money on a special department to take such cases in hand and investigate them thoroughly. He had thought it required a tight plug in the vagina to cause a rupture of the uterus. This case proved that they could not artificially dilate a cervix; they tore it, but very few were aware that they did so. He had never examined a woman whose os was artificially dilated without finding a cervical tear.

Dr. Ashe thought chloasma might be due to some

form of toxæmia.

Dr. FitzGibbon recalled a case in which rupture of the cervix extending into the lower uterine segment was found about an hour after delivery, though there had been no previous indication of the rupture.

Dr. JELLETT suggested that the cervix was probably in a condition of abnormal softening, in which state it would easily tear. It had been stated that if one found a cervix torn it was proof that the woman had been delivered artificially, but he had seen a patient who had never had a full term child, and never had an operation of any kind, in whom the cervix was

Dr. Pureroy recalled his record of a case in which a lady received a large bilateral tear, as a consequence of the birth of twins that were so small that his ring fitted on to their wrist. He had recorded it as a positive proof that the cervix could tear independently of instrumental delivery. He had never seen a cervix artificially opened without tearing. In Dr. Solomon's case the cervix was not soft. His experience was that it was the hard cervix that tore.

Dr. SOLOMON, in reply, said he had seen a good many cases where patients had said they had never had instruments, and yet the cervix had been torn. He thanked the speakers for their remarks.

A WOMAN named Thompson was on June 17th summoned at the Manchester City Police Court for having failed to notify within twenty-four hours the death of a child she had to nurse. This was the first case in Manchester under a provision of the Children Act. It was explained that the woman was registered by the Chorlton Guardians to nurse one child. The death occurred on May 24th, but was not notified at the coroner's office until over thirty-one hours after the expiration of the period allowed for registration. The summons was dismissed, as the magistrates decided that the woman had acted through ignorance.

# OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD IN THE ROOMS OF THE MEDICAL SOCIETY OF LONDON, ON THURSDAY, JUNE 10TH, 1909.

Mr. W. H. JESSOP, F.R.C.S., in the Chair.

MR. FREELAND FERGUS showed a case operated upon 'paralytic ptosis" by his method of resection.

Mr. HERBERT FISHER showed an unusual form of cataract, bilateral, in a girl.

Mr. Jessop brought forward a case of "bilateral with complete ophthalmoplegia externa.

Mr. BERGIN showed a case with an unilateral swelling, and Mr. BLAIR one of pemphigus of the conjunctiva; while Mr. HERBERT BELL exhibited a case of unusual elastic adhesion between iris and cornea.

Mr. ARNOLD LAWSON exhibited a case of "congenital glaucoma" treated by Lagrange's iridectomy. The latter was discussed by Dr. Weeks (of Philadelphia), Mr. Brooksbank James, Mr. Treacher Collins, Mr. Odillo Maher, and Mr. F. R. Cross.

Mr. P. H. ADAMS read two papers, the first on A FAMILY WITH CONGENITAL DISPLACEMENT OF LENSES.

The series consisted of a mother and seven out of her nine children who suffered from this condition, but no other instance could be found in the family. In three of the cases the lenses were displaced downwards, instead of the more usual displacement upwards, while in the eldest boy the dislocation was complete, thus leaving the pupil clear of the lens. two members of the family who were unaffected had perfectly normal eyes.

The second paper was on

A FAMILY WITH CONGENITAL OPACITIES OF LENSES.

In this family the great-grandfathers, grandmother, father, and four of his chidren (out of five), as well as the father's sister, showed the peculiar opacities of the lens known as Steller cataract. Posteriorly there were from 3 to 8 primary rays, and numerous secondary ones, while some of them showed Y-shaped markings on the anterior surface as well. The opacities slowly increased throughout life, especially in the front of the lens, while the posterior markings were broader and less defined.

Messrs. A. Hill Griffith and A. W. Ormond read a paper entitled

A CASE OF RETINAL DISEASE WITH MASSIVE EXUDATION AND ARTERIO-VENOUS COMMUNICATION.

The patient was A. J., a female, æt. 31. The left eye had been removed for secondary glaucoma by Dr. Hill Griffith ten years ago. The fundus of the remaining eye showed very tortuous and distended retinal vessels, with varicosity of several of them, and a red blurred optic disc. In the extreme periphery of the fundus, deep to the retinal vessels, was a whitish mass, the limits of which could not be seen. Issuing from the anterior border was a large vein, and running to it an artery somewhat similar in size and colour. The changes in the fundus were probably all due to vas-cular disease. The interest in the case was furthered by the fact that the other eye of the patient was removed for secondary glaucoma simulating an intraocular growth, and, on examination, it proved to be a case of extensive sub-retinal exudation, with retinal detachment and an old organising hæmorrhage, but no growth. The patient's sister also lost an eye from a similar cause, and the same condition was found on pathological examination.

Dr. GEORGE MACKAY reported a very unusual

appearance-

AN EPITHELIAL FILAMENT SIMULATING A THREADWORM in the anterior chamber of the eye of a little girl, æt. 7. The child had always enjoyed good health, had no special illness, had never suffered from worms, and had not complained much about the eye. The filament had been first noticed when she was eight months old. No independent movement had ever been detected in it, but the parents were under the impression that it was slowly increasing in size. The eye was occasionally a little irritable, with a tendency to Iachrymation, and a trace of ciliary injection. The tension was

normal, the media otherwise transparent, and the fundus healthy. The pupil responded to light, though less mobile below than above. At the periphery of the iris, close to the anterior chamber angle, between the 5 and 6 o'clock meridians, a buffy-grey filament about a millimetre in diameter emerged between the fibres of the iris, ascended in close relation to the posterior aspect of the cornea for 3 or 4 millimetres, then bent backwards towards the lower border of the pupil, and, crossing the vertical meridian of the anterior chamber, appeared to rest lightly in contact with the sphincter surface of the iris. Thereafter it bent downwards once more, following the plane of the iris nearly in the 7 o'clock meridian. The structure terminated in a slightly bulbous free extremity, which did not re-enter the iris, nor extend to the angle of the anterior chamber. The arched filament had thus a slight spiral twist from before backwards. The refraction of the eyes was about emmetropic. The vision of the right eye 6/12 fairly, and the left 6/6. The child was put under chloroform, and, through an incision made at the corneo-scleral junction, a little to the nasal side of the filament, the foreign body was successfully removed, though breaking into two pieces on account of its brittle structure.

From the pathological examination made by Dr. Shennan, of Edinburgh, and Mr. A. E. Shipley, of Cambridge, no confirmation was obtained of the presence of a parasite. Microscopic sections showed that the filament was mainly composed of stratified epithelium, with a little loose connective tissue and some melanine pigment. Discussion was invited as to its probable origin—e.g., in a congenital displacement of part of the epithelium from the anterior surface of the iris, or a capsulo-pupillary vestige.

Mr. W. H. H. Jessop gave a report of the Inter-

national Committee on the

UNIFICATION OF THE NOTATION OF VISUAL ACUITY AND OF THE MERIDIANS OF ASTIGMATISM.

The Committee, after consideration, came to the following conclusions:—(1) That the meridians of astig-matism should be measured and represented as the observer looked at the patient. (2) That the axeshould be measured and represented in the lower semi-circle of the trial frame. The numbering of the axes should start from the middle line of the face in each eye, and proceed downwards and temporalwards. The zero would therefore lie at the nasal end of the semi-circle, and 180° at the temporal end; 90° would be below and midway between these points. The Committee also agreed that for international test type, numbers should be used. Landolt's ring was also thought to be a suitable object. The unit of measure was an angle of r minute, and the figures were to be constructed on this unit. The types were to be constructed as regards size on arithmetical progression, and the standard distance at which they were to be seen should be 5 metres. The source of light was to be diffuse daylight, if possible, opposite the types, and not laterally.

#### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 20th, 1989.

DEPOPULATION.

ALCOHOLISM is another plague worthy to be placed alongside tuberculosis. It threatens not only the health of the individuals who indulge in alcohol, but the future of the race.

The study of alcoholism is of recent date. It was a Swede, Magnus Huss, who, in 1852, was the first to draw attention to the evil effects of alcohol on the social life of peoples, and for the last thirty years it has been a live question in France.

Five kinds of alcohol may be found in beverages: methylic, ethylic, prophylic, butylic, and amylic alcohol. Ethylic alcohol, distilled from grain, tubers,

sugar-cane, etc., is almost exclusively used for consumption; methylic or wood alcohol is used for adulteration. Alcohol, even rectified and freed from impurities, is toxic in itself, as proved by Rabuteau in 1870 and later by Joffroy and Servaux.

The production of alcohol in France is very con-

siderable. The vine plantations cover in the aggregate 4½ millions acres, and the wine crop of 1908 exceeded 60 million hectolitres (hectolitre = 22 gallons). Beer forms the chief drink of the northern departments, attaining 300 quarts per head of the population, while 350 quarts of cider per capita are consumed in the north-west of Brittany.

The production of distilled alcohol, which was about 900,000 hectos per year some 60 years ago, reached the formidable figure of 3,656,000 hectos in 1900, and of this amount only about 180,000 hectos were exported; the rest was consumed in the country under the form of cognac, eau de vie, liqueurs, aperitifs,

and absinthe, and represent 15 quarts per head.

The French nation, says Prof. Courmont, is, without doubt, the nation which drinks the most alcohol. If, instead of calculating roughly the amount consumed per capita, abstraction were made of young children, sick people, total abstainers, it would be found that an adult Frenchman drink 100 quarts of alcohol at 100° per year!

In certain departments, as La Manche and La Normandie, Côte du Nord, Pas de Calais, men, women, and children—babies, even—take a considerable amount of alcohol daily.

The rank that different countries take as regards the consumption of alcohol per head of the population appear in the following statistics, drawn up in 1806:-

France			14	litres	19.
Belgium	•••	• • • •	10	,,	59.
Italy		•••	10	,,	22.
Germany	• • •	•••	9	,,	34.
England	• • •	• • •	9	,,	23
United States	• • •		6	,,	07
Sweden	• • •	• • •	4	,,	39.
Norway			3		31.

Consequently, France takes the lead, which is not very astonishing, as the law allows one café to every 80 inhabitants, while in the large cities in nearly every third house there is a drinking-shop.

Is alcohol a food? The question was answered in

the affirmative by Duclaux, and later by Chauveau, Atwater, and Benedict.

No doubt a portion of the alcohol ingested is utilised, and in a purely scientific point of view it may be admitted as a food, but one that should be used with prudence, for two reasons: it is an expensive food and a poison.

The deleterious effects provoked by the excessive use of alcohol are well-known, and might be résuméd thus: mechanical irritation of the digestive tract, dehydration of the tissues, dilatation of the capillaries, fatty degeneration, peri-vascular sclerosis.

The lesions produced are very complex in their

- (1) Digestive organs: acute or chronic gastritis, intestinal catarrh, cirrhosis of the liver, fatty degeneration of the liver, chronic peritonitis, pancreatic diabetes.
- (2) Heart and vessels: fatty degeneration, arteriosclerosis.
- (3) Respiratory tract: pharyngitis, laryngitis, predisposition to pneumonia, gangrene, tuberculosis.
- (4) Nervous system: central cerebral derangement, meningitis, atheroma of the cerebral arteries, peripheric neuritis.

From a clinical point of view, acute alcoholism may produce delirium tremens or epileptic seizures (absinthe drinkers).

The relation between alcoholism, or more particularly absinthism, with criminality and lunacy, is firmly established. The increase of crime and mental disease in France is evidently due to the increase in the consumption of alcohol.

In 1861 the number of lunatics in the different asylums in the country was 2,902; in 1896 the total number was 22,671, of which 50 per cent. were

absinthe drinkers, and in this proportion the femalesex formed a large minority.

The question of repercussion of chronic alcoholism on the race has been proved beyond all doubt by competent authorities, and the principal hereditary effects are: dipsomania, troubles of the nervous system, anatomical malformations.

The children of alcoholic parents feel from the age of 15 or 20 an innate want of alcohol, and become alcoholic in their turn. The cellular elements demand their natural simulant, like those who are addicted

to morphia.
"Your father drank," says the proverb, "and you will drink; you will drink more than your father, and your children more than you."

The cerebral troubles are manifested by epilepsy, hysteria, convulsions, neurasthenia, absence of moral

stability, violence of character, loss of mental balance. The congenital lesions due to alcoholism are numerous: malformation of the limbs or organs, infantilism, hydrocephalus, idiocy, essential epilepsy, etc.

Dr. Legrain, who has for years fought the good fight against alcoholism, studied the history of 215 alcoholic families, representing 508 individuals. The first generation had a large number of stillborn children or deaths in infancy, while 168 were degenerated both physically and mentally. In the second, all the families had degenerated, whilst of the third there only remained 17 individuals, almost all idiots. FURUNCULOSIS.

Furunculosis, as is well known, is a lesion of the pilo-sebaceous apparatus provoked by staphylococci. Dyspepsia, diabetes, arthritism, local irritation are secondary causes.

The local treatment consists in sulphur baths:-Monosulphide of sodium, 1 oz.

Carbonate of soda, 6 oz.

Chloride of sodium, 3 oz.
As soon as a boil appears it may be touched with tincture of iodine. If suppuration has set in, an inci-sion is made, and, after extraction of the pus, the cavity is filled with:

Sublimed sulphur, Camphor, } equal parts,

Glycerin, q.s. while a plug of glycerin is placed over the orifice. The general treatment consists in ingesting a mixture

of honey and sulphur :-

Sublimed sulphur, 5 dr. Camphor, 10 gr. Honey, 1 oz.

A teaspoonful before each meal. After each meal, one of the following wafers:

Calcined magnesia, 11 dr. Lactose, 11 dr. Bicarb. of soda, 1 dr. Carbonate of lime, 1 dr. No. 12.

#### GERMANY.

Berlin, June 20th, 1909.

AT the Verein für Innere Medizin a discussion on Hr. Heubner's paper on

THE DIFFERENTIAL DIAGNOSIS OF THE ACUTE AND EXANTHEMATOUS DISEASES

took place.

Hr. Plehn said that he had found patients with a measles rash, who a few days later developed a scarla-tina rash, which was followed by an ordinary scarlatina. He had got the impression that such cases were-scarlatina with an atypical exanthem. In any case he had seen cases in which measles and scarlatina developed simultaneously. He had also seen true re-lapses after scarlatina, with a typical course of the disease followed by desquamation. He had also seen repeated attacks of scarlatina in the same individual after the lapse of years. These often ran an atypical course, especially as regarded the rash. As regarded the 4th and 5th disease, he was sceptical.

Concerning the differential diagnosis between measles

and scarlatina, which was sometimes very difficult, the diazo-reaction in measles never really failed, whilst in scarlatina it only showed itself in very bad cases. A distinction between the injection exanthem of the injected cases, and the scarlatina exanthem was sometimes scarcely possible.

Hr. Fuld expressed regret that a plan that he had worked out for biological examination had not been carried any further by Hr. Heubner after it had failed in one case.

Hr. Citron remarked in regard to the negative results that had been obtained with antigens that French inquirers had always obtained positive results with streptococci from scarlatina cases. Schleussner had had like results without being aware of the labours of the French inquirers. Whether extract from measles streptococci also had a positive result in scarlatina required further investigation.

required further investigation.

Hr. Heubner, in reply to Plehn, said that he had never seen a prodromal rash in scarlatina, he considered it a double exanthem. He had several times recently seen a kind of rötheln and measles occurring simultaneously. He agreed with Plehn in regard to the diazo-reaction in measles; but the reaction was seen not very rarely in not very bad cases of scarlatina. Sometimes it was not possible to distinguish a serum exanthem from a scarlatina rash.

According to the Deutsche Med. Zeitung, Prof. Paul H. Römer makes the announcement that his new method of using tuberculin for diagnostic purposes consists in injecting small doses of tuberculin solution into the skins of animals, and then, when the animals have become ill, measuring with great exactness the infiltration that has taken place.

The Prussian Minister for Medical Affairs makes the announcement that owing to the increased cost of preparing the curative serum for cerebro-spinal meningitis, a charge will in future be made of 2 m. per ccm., as an aid in partly covering expenses.

#### AUSTRIA.

Vienna, June 201h, 1909.

HIPPURIC ACID AND PAIN IN MICTURITION.
PINELES gave an exhaustive account of his clinical examination of 110 cases, which came under his notice complaining of great pain in passing urine without any of the real phenomena or other vesicle trouble, such as sudden attacks of gout or tophi being present.

He divided these cases into three groups: The first comprising 46 of the cases occurring in females at the climacteric period, and having all the symptoms of pains in the arms, hands, shoulders, back, etc. This form is relatively frequent, and seems to be due to the involution and alterations occurring in the genital apparatus. The second group comprises 19 of the cases, and occurs mostly in the senile state. A large number of these were present in elderly females associated with the painful sensations of the climacteric, and may possibly be due to retarded involution in the aged. The third group comprehends individuals suffering from functional or nervous diseases, among which were four females afflicted with myoma, endometritis and oophoritis, and twelve males with functional disturbance of the genitals and imperfect vita sexualis. Thus we may conclude that two-thirds of the whole cases of the so-called painful micturition had their pathological origin located in the genital apparatus. Pineles was inclined to isolate this disease under the name of genital pseudo-gout occurring in three groups under the terms climacteric, senile and

#### NATURAL FEEDING OF INFANTS.

Jaschke followed with a minute description with the physiological technique of the natural feeding of infants. He arranged his subject into regular periods of teeding, and considered three or four hours a sufficient interval, with six or eight hours' rest at night.

The best method he thought of controlling the weight and growth of the child was by regularly weighing. A rapid increase of weight would point to overfeeding, which should be carefully guarded against. The quantity taken at one meal when fed at the breast can only be measured by weighing before and after. The first food after birth will depend very much on the vigour and strength of the infant, but as a rule, it should never be put to the reast during the first day.

The cause of many evils in the child's history depends very much on the irregular practices at this period of its life. In many cases, however, the child is placed at a disadvantage with an abnormal mammilla, such as the narrowing of the channels requiring greater force than the infant possesses to empty the organ, and in consequence the breast is never entirely cleared of the lacteal secretion. To overcome this difficulty the milk should be drawn with an exhauster and given to the child. The time that an infant should be allowed to remain at the breast varies from 15 to 25 minutes in a healthy child, but may be extended in a feeble one. Where the milk secretion is insufficient, four or five times exhausting with a breast pump may increase its flow in simple cases, but more difficult ones must be treated with Bier's congestion method. For a depressed nipple either the exhaust pump or massage should be practised.

# FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN. This Section of the Royal Society of Medicine held its annual provincial meeting in Edinburgh on the 18th inst. The proceedings were inaugurated by a luncheon given by the local executive committee, and thereafter the meeting proper was held in the Sick Children's Hospital. A number of interesting cases were demonstrated. Dr. George Gibson showed a case of patent ductus arteriosus, Mr. Scot Carmichael a case of Sprengel's deformity of the scapula with a a case of Sprengers deformity of the scapula with a curious webbed condition of the skin of the shoulder, and Mr. Harold Stiles a series of surgical cases of great interest, including examples of transplantation of the ureters into the pelvic colon for epispadias in the female, cholecystenterostomy for obliteration of the bile duct from injury, and sub-periosteal removal of the whole diaphyses of the long bones for tuber-culous osteomyelitis. In connection with the last group of cases, Mr. Stiles pointed out that if the cases were operated upon early enough, before the perios-teum was involved, recurrence did not take place. When the diaphysis was removed the epiphyseal cartilage was left in situ, and from it, and the periosteum, a new diaphysis was formed. After an interval for tea, and the inspection of a museum which had been got together, the meeting resumed its sederunt for the purpose of hearing papers. Among those read were notes on the treatment of hyperpyrexia in children by Dr. Burnet, a method of estimating the vitality of the leucocytes, and a comparison between the toxicity of the blood serum in rheumatism and chorea, by Dr. McAlister, a record of a case of irreducible intussussception treated by lateral anastomosis, a case of acute leukæmia with atypical cells in the blood, by Dr. Lapage. The scientific proceedings, which in the end had to be somewhat abbreviated for lack of time. were brought to a close shortly before 7 o'clock, and later in the evening the members of the Section, with a number of invited guests, dined together in the Caledonian Hotel. Dr. George Gibson, who presided, gave the toast of the evening, "The Health of the Society for the Study of Disease in Children," to which Dr. George Carpenter replied, urging that a which Dr. George Carpenter replied, urging that a larger number of Edinburgh men should join the Society than was the case at present. The toast of "The Guests" was proposed by Mr. Stiles, and replied to by Dr. Norman Walker. The sectional proceedings were presided over by Dr. George Carpenter, London, and among those who attended the meeting from a distance of the property of the process of t distance were Drs. Hugh Lett, Spriggs, Sutherland. Tubby, Sydney Stephenson (London), Dr. Macalister (Liverpool), Dr. Lapage (Manchester), Dr. Mackerra (Aberdeen), Dr. Stalker (Dundee). A number of local medical men, not members of the Society, were also present at the meeting. On Saturday a golf match

was arranged for the members present.

EDINBURGH UNIVERSITY.—RESIGNATION OF PROFESSOR JOHN CHIENE, C.B.—At the last meeting of the University Court an application from the Professor of

Surgery for permission to retire was granted, to take effect as from August 31st next. Professor Chiene has resigned on account of failing health; he obtained leave of absence in the end of last year, but the rest from work has not done him sufficient good to warrant him resuming active work in the University. Professor Chiene was appointed successor to the late Professor Spence in 1882, so that he celebrated his "silver wedding" as Professor two years ago. On that occasion he addressed his class on things of bygone days, and the address, subsequently published under the title of "Looking Backwards," was full of interesting reminiscence and entertaining anecdote. Professor Chiene was an Edinburgh student; he was a good athlete in his day, and has always manifested a keen desire to encourage outdoor sports among the students. He graduated with Honours in 1865, and among his masters he numbered Goodsir, Syme, and Joseph Lister. His whole life and energies have been devoted to carrying out Goodsir's dying injunction to him—"Teach the students, Mr. Chiene"—and he has let no professional claim come between him and his selfimposed task. During the South African War he was Consulting Surgeon to Her Hajesty's forces, and for his services he was made a C.B., and was mentioned in despatches. He is an LL.D. of Glasgow University, and has held many other important offices. John Chiene has been much beloved by his students, to whom his geniality, his hospitality, and his untiring devotion to their interests has greatly endeared him, and his resignation will cause a blank in the medical faculty which will be difficult to fill.

GLASGOW UNIVERSITY.—Under the will of Dr. J. Hall, M.D., St. John's Wood, London, who left estate of the gross value of £88,366, the Senatus of the University of Glasgow (of which Dr. Hall was a graduate) will benefit to the extent of about £35,000, This has been left to found the "Hall Tourist England". This has been left to found the "Hall Tutorial Fellow-ships" in surgery, medicine, and midwifery, to be awarded after examination to graduates of not more than five years' standing. Each Fellowship is to be of the value of £200 per annum, and there are to be as many of these as the income of the trust funds will admit of, any surplus to be applied to the purchase of teaching appliances or prizes. The Fellowships are to be held apart from any other endowment or scholarship, and the holders must reside within three miles of the University, and are to devote their whole time to the practical instruction of the students under the direction of the professors, and may not engage

in any private practice or tuition.
RUCHILL HOSPITAL.—The affairs of Ruchill Hospital are again to be dragged into publicity through the decision of the Glasgow Town Council to accept and act upon a petition signed by 18,000 citizens for an independent inquiry "into the administration of Ruchill Hospital from the date of the Local Government." ment Board inquiry up to the present date" by a committee of citizens "drawn from the following bodies: three from the Faculty of Physicians, three from the Faculty of Procurators, three from the Merchants' House, and three from the Trades Council, with a neutral chairman, such as Sir Donald MacAlister or Dr. Robert Gourlay." It is to be hoped that this inquiry will bring the apparently interminable disputes about Ruchill Hospital to an end.

PROFESSOR CLELAND, GLASGOW.—Professor Cleland, who for thirty years has occupied the Chair of Anatomy in the University of Glasgow, has intimated his resignation. His resignation was not expected. It is prompted by a desire for a well-earned rest, and not by reasons of health. The only name that has reached us as a candidate for the vacant chair is that of Professor Buchanan, whose "Manual of Anatomy" in the "University Series" is so well known.

#### BELFAST.

QUEEN'S COLLEGE.—At a meeting of the Better Equipment Fund held last week, it was stated that a sum of £5,100 had been invested in Corporation Stock, and that this had been ear-marked for the purchase of an athletic ground. There has been great difficulty in finding a suitable ground, as estate owners

in the suburbs of the city show a tendency to "hold up" their land for building purposes, but it is to be hoped that some of the wealthy and influential merchants on the committee of this fund will give the matter serious attention, and that soon the students may enjoy their games on a good ground of their own.

ROYAL MEDICAL BENEVOLENT FUND.—The annual

meeting of the Belfast and County Antrim Branch of the Royal Medical Benevolent Fund of Ireland was the Royal Medical Benevolent Fund of Ireland was held in the Medical Institute, Belfast, on Friday, June 18th, the President (Professor Johnson Symington, F.R.S.) in the chair. The report showed that a total sum of £164 had been raised during the year, including £6 11s. from the Belfast Medical Students' Association. There are still some 70 or 80 members of the profession in Belfast who give nothing, and in the county there are only 40 subscribers among 200 practitioners. Dr. Richard Purdon, the late hon. secretary, said that on the whole Ireland did not do badly in the way of medical charity. In England there were 25,000 medical men, and their contributions to the British Medical Benevolent Fund amounted to £1,700, or 1s. 4d. per head. In Ireland they had 3,000 medical men, and their contributions were £541, or an average of 3s. 7d. per head. There was no reason why they should not improve upon this. On the motion of Dr. Gaussen, seconded by Dr. Wadst worth, Professor Symington was re-elected President, and on the motion of Dr. Calwell, seconded by Dr. Maguire, the committee was re-appointed, and also the hon, secretary, Dr. Victor Fielden.

TYPHOID AND WAKES IN LONDONDERRY .- At the Derry Petty Sessions last week a woman was summoned and eventually fined for holding a wake for two nights on the body of her husband, who had died of typhoid. It appeared that the family refused to let the man go to hospital, as was advised, and that after his death a notice was sent warning the widow that a wake must not be held. In spite of this the wake was held for two nights, hence the prosecution. The de-fendant had rendered herself liable to a penalty of £5, but as she was very poor the magistrates let her off with a penalty of rs and a magistrates let her

ff with a penalty of 5s. and a warning.
STRABANE DISTRICT NURSING SOCIETY.—The fifteenth annual meeting of this society was held last week, the Duchess of Abercorn presiding. The report stated that little or no good seems to have resulted from the Tuberculosis Exhibition and the lectures in connection Tuberculosis Exhibition and the lectures in connection with it. The old state of things continues, notwithstanding the advice of the visitors of the Women's National Health Association, who have gone through all the town. One thing strikes one as remarkable in the report of the meeting, and that is that no medical man seems to have taken part in it. If such a society is properly worked it ought to be of the greatest help to the profession, and if it is not so, the local influence of the profession ought to be sufficient to have things altered things altered.

MEDICAL GOLF .- The annual competition for the Lindsay Cup was held last week on the Ormeau Golf Club's links at Belfast, and resulted in a win for Mr. Andrew Fullerton, F.R.C.S.I.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

SICKNESS AFTER ANÆSTHESIA

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-Dr. Blumfeld has put practitioners under an obligation by his extremely helpful paper under the above heading in your valuable journal. I find nothing to criticise in it; but I think it leaves out a small, but not unimportane, class of cases to which I should like to refer. These are cases in which nausea and vomiting seem mainly or entirely due to the swallowing of blood and mucus during removal of adenoids. My attention was first drawn to such cases about twenty years ago, when, as a very junior practitioner, I had charge of a patient, a boy, et. 15, under a leading surgeon of the day. The operation was prolonged, and much blood and dibris passed into the stomach.

The boy complained of extreme nausea for more than 48 hours. He could take no food; retching was frequent, but only a few mouthfuls of bloody fluid were got rid of with each effort. In all such cases it has since been my practice to administer a simple emetic with plenty of warm water; and to repeat this if not satisfied that the stomach is thoroughly cleared of blood. I find that this treatment almost invariably puts an end to the nausea; and if, whilst giving plenty of milk and soda water, a saline dose is administered, all the symptoms rapidly vanish, and convalescence is at once established. It is evident in many of these cases that the nausea is mainly due to mental causes. The patient's horror of the blood in the stomach 'makes him sick."

I am, Sir, yours truly, AN OBSCURE PRACTITIONER.

June, 18th, 1909.

PREVENTION OF DENTAL CARIES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR,—In every department of preventive medicine Six,—In every department of preventive medicine the aim should be to get at prime causes, and this applies as strongly to dental disease as to any other. The prime determining causes of dental caries are, first, innate structural defects in the teeth; second, crowding and irregularity due to small, ill-formed jaws; and, third, septic conditions of the mouth. Well-formed enamel is as hard as limpid quartz; the worst formed is chalky in texture; and patches of illcalcified tissue of infinitely varying quality are found in all imperfect sets of teeth. Given first-rate enamel and well-shaped jaws, and it is astonishing the amount of neglect the teeth will endure without harm, whereas the highest skill and the most assiduous attention will not save organs the tissues of which are inherently defective. These facts do not seem sufficiently recognised in Mr. H. R. F. Brooks's excellent Inaugural Address at Birmingham, which you report to-day. If we could put an end to constitutional discounting time to the saves of content which I have eases giving rise to the causes of caries which I have named, dental decay would be enormously diminished at once. Among these diseases I should give a first or osseous appendages, they always seem as ill-formed as the bones in rickets. Further, the jaws are often ill-formed and ill-shaped in this disease, whilst the secretions of the mouth during childhood with rickets are mostly foul to a high degree. Now rickets is a disease of malnutrition. Its main cause is improper feeding. It is easily preventable by simple measures, and its prevention would prevent dental decay. If one wants to see full illustration of this fact, it may be found in an examination of the mouths of the children of typical well-fed Scotch or Irish peasants, and rickety, narrow-chested wastrels that swarm in the slums of our great towns. Inferior teeth are only one manifestation of general physical inferiority; the defect can be prevented and should be dealt with by measures directed to improvement of the whole organism.

I am, Sir, yours truly, M.R.C.S., L.D.S.

June 16th, 1909.

THE EMOLUMENTS OF CHRISTIAN SCIENCE. To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—The letter of Dr. Duke printed in your issue of the 16th inst. has reference to a matter of fact, not to a matter of opinion. In these circumstances to permit the person attacked to reply is simply a question of fairness, and I think you will extend this courtesy to us in this instance as you have done in the past.

It is to be hoped that Dr. Duke's readers are better acquainted with the passage from Matthew which he quotes than he appears to be, though it must be confessed that if they are it will not exalt their opinion of his logic. It is quite true that Jesus commanded his disciples to "Heal the sick, cleanse the lepers, raise the dead, cast out devils": that is why Christian Scientists are insisting to-day on another of his commands to preach the Gospel and to heal the sick, and insisting that these two clauses are inseparable. It is also true that he added to these words the complement, "freely ye have received, freely give," but it is surely equally plain that the "freely" referred to the fact that the healing was to be without stint. Dr. Duke seems to have a suspicion of this, for he omits the further injunction of Jesus to the dis-ciples to make their home with those whom they helped, and he leaves out the terrible words in which Jesus wound up His charge to the apostles with a denunciation of those who failed to provide for them.

Between the Palestine of the first century and Western Europe of the twentieth century there is a great gulf fixed. It is no longer possible for those who are striving to heal the sick to enter and abide in the houses of those whom they are helping, providing themselves with neither gold, nor silver, nor scrip, nor coats, nor shoes, nor yet staves; and so some recompense, of a nature more adaptable to the complex civilisation of to-day, has been substituted by the world for this primitive method. For, with all deference to Dr. Duke, the world does recognise the justice of Jesus saying that "the workman is worthy of his meat" and "the labourer is worthy of his

The old system did not die in a day. The guesten halls of the old monasteries provided some such hospitality to travellers, and in these monasteries, at first in connection with these guesten halls, there came into being the germ of the hospital system. That is into being the germ of the hospital system. That is why the hospital was first known as the hotel Dieu. Anybody who really knows anything about the practice of Christian Science knows that the fees taken by Christian Science workers are, at all times, of the smallest description, and are reduced to practically nothing at all—very frequently absolutely to nothing at all—to meet the means of the patient. Perhaps, however, the clearest rebuke to Dr. Duke's argument is contained in St. Paul's words to the Church in Corinth, "If we have sown unto you spiritual things, is it a great thing if we shall reap your carnal things?"

I am, Sir, yours truly, FREDERICK DIXON.

June 18th, 1909.

[We have printed the above, as we wish to be absolutely fair to everyone, no matter how much we may differ from his opinions and beliefs. It seems to us, however, that Mr. Dixon has failed to refute, or even remotely to answer, Dr. Duke's argument, which we take to be as follows: The "Christian Scientist" take to be as follows: The "Christian Scientist" healer undertakes to cure disease "by prayer and poultice." Will he be paid by results, or will he follow the advice given by the Master (Matthew x., 8, 9), "Heal the sick; freely ye have received, freely give." Mr. Dixon has written many words, but, so far as we can gather, he admits that "Christian Science" healers receive payment. No amount of excuse or explanation can get behind that fundamental even on Mr. Dixon's own showing, in his facts, and we are at a loss to understand how the latter gentleman can attempt to discuss the matter with an appeal to fairness.

The element of money-making is bound to cast a slur upon any semi-philanthropic or quasi-religious scheme. It is no more necessary for a "Christian Scientist" to make money out of his grotesque per-suasions and beliefs than it was for the early Apostles to demand money for their ministrations. Reduced to its ultimate analysis, "Christian Science" healing is a form of false medical practice, constituting, when money is made out of it, the offence of obtaining money under false pretences. It is to be hoped the Church of England will keep away from this more than questionable thing.—ED. MED. PRESS AND CIRCULAR.]

Cork Medical and Surgical Society.

At the recent annual meeting of the Cork Medical and Surgical Society the following officers were elected for the Session 1909-10:—President, Professor D. T. Barry; Vice-President, Dr. J. Booth; Honorary Treasurer, Dr. C. B. Pearson; Honorary Librarian, Dr. E. Murphy; Secretary, Dr. J. T. O'Connor. A Council of seven members was also appointed.

#### OBITUARY.

FREDERICK NUTCOMBE HUME, M.R.C.S., L.R.C.P.

WE regret to record the death, on June 14th, of Dr. Frederick Nutcombe Hume, Medical Superintendent of the Metropolitan Asylums Board's North-Western Hospital, and Major in command of the and London Division of the Royal Army Medical Corps (Territorial Forces). Dr. Hume had seen service as a surgeon in no less than four campaigns in the Balkans. The mourners at the funeral included, in addition to members of the family, Professor Smith, Mr. Cole, and Mr. A. Boden, members of the Metropolitan Asylums Board; Mr. Duncombe Mann, clerk to the Board; Dr. A. H. Downes, of the Local Government Board; Dr. G. F. McCleary, Medical Officer of Health for Hampstead; Colonel Andrew Clark, Colonel Magill, C.B., Colonel W. R. Smith, Major Ballard (representing Major-General Vesey-Dawson, C.V.O.), Major Irwin Palmer, Captain Caldwell Smith, Captain Coffield, and Lieutenant A. J. Martin, brother officers of the deceased and Drs. G. Pugh, H. Cuff, C. E. Matthews, Prausnitz, McCombie, Bruce, Caiger, Goodall, and Wilcox.

#### WILLIAM ALLINSON M'LACHLAN, M.D.GLASG.

WE regret to announce the death of Dr. W. A. M'Lachlan, at his residence, Dumbarton, after a long and painful illness. Dr. M'Lachlan, who was in his 61st year, was laid aside by illness about a year ago. In early life he assisted his father, the late Mr. David M'Lachlan, master slater and plasterer, and at an early age he successfully founded a branch of the business in Dumbarton. A few years later he became a medical student, and after a meritorious career graduated in 1874. After a brief period as Medical Officer to the parish of Tarbolton he returned to Dumbarton and rapidly built up an extensive practice by reason of his business habits, ability, and industry. For many years he was an active member of the Town Council, and served as a magistrate. For fully twenty years he was Medical Officer to the parish of Cardross. He was also Surgeon-Captain in the local Artillery Volunteers. Dr. M'Lachlan was the author of numerous contributions to lay and medical journals, and he was a graceful and fertile writer on poetical subjects. In 1874 he made several experiments to demonstrate that diphtheria began as a local affection in the throat, and that the constitutional symptoms followed the local infection.

## SPECIAL ARTICLES.

## STANDARDS OF PURITY FOR FOODS.

At the recent meeting in London of the Seventh Congress of Applied Chemistry, the section dealing with Bromatology devoted considerable attention to the advantages and disadvantages of legally binding standards of purity for foods. Papers were read by Continental and British observers on methods of analysis of many of the more important articles of food.

The paper by Mr. C. G. Moor and Mr. William Partridge, while dealing with a greater number of foods than we have space to mention here, dealt in particular with the important subjects of standards for milk and for infants' food, and hence we have considered it of sufficient interest to reproduce here some of the suggestions made by the authors.

Their paper was prefaced by introductory remarks indicating that, in the authors' opinion, the application of standards in this country, although such application as at present exists has been limited to a very few articles, has uniformly produced a beneficial result.

They considered that the adoption of standards of purity was of advantage to the public because it insured them against gross adulterations which had been found to be prevalent in the past, when no standards of any kind were in operation.

So far as the producer or trader was concerned, the authors believed that the adoption of standards would tend to put a stop to the unfair competition due to the sale of adulterated articles, and moreover that it was only fair to traders that they should, by the free and full publication of standards, know precisely what was expected of them. Standards might bepublished, which for a given period might be tentative only, in order that before they were finally incorporated into an Act, they might be discussed and revised if they were found either too stringent or too lenient.

THE MEDICAL PRESS.

From the point of view of those who have to apply the Foods and Drugs Acts, the adoption of standards appeared to the authors to be likely to conduce touniformity of administration.

At the present time each analyst when reporting on any sample sent in to him had to form his own independent opinion on it, the result of which was that certain articles were allowed to pass in some districts which were condemned in others.

The adoption of standards found favour in the United States and in the Commonwealth of Australia, and was also a matter of earnest consideration in other countries.

In dealing with the subject of infants' fcods, the authors pointed out the necessity for special legislation to insure that their composition should be suitable, and that the directions given for their use should specify what quantity is intended to be used in a period of 24 hours, and that the claims made for them should be true in substance and fact. The authors pointed out that recommendations to secure these highly important points had been published by them some years ago, and that the recent regulations of the Victorian Government embody the same recommendations almost word for word.

In dealing with the subject of milk, the standard which was first fixed for use in this country as a minimum percentage of fat was 2.5, it was later on raised to 2.75, and is at present fixed at 3.0 per cent. In many other countries the standard was 3.5, but the difficulty in raising it above the figure now fixed was that there are a certain number of milks which are naturally no higher than 3.0 per cent. in fat.

Such natural poorness is however rare, and the suggestion of the authors was, that the authorities in each district should regularly publish the figures obtained by the Public Analyst on all the milks analysed, with the name of the vendor. In this way they considered that it would become known that the majority of vendors regularly supplied a good and genuine milk, and that the public would learn to discriminate between them and the vendors who make it a regular practice to impoverish milk intentionally. In the authors' judgment the force of public opinion would cause the practice of this unfair form of competition to die out, and that in this way a general improvement in our milk supply would result.

#### REVIEWS OF BOOKS.

INFECTIOUS DISEASES. (a)

In the preparation of the second edition of this book, Dr. Goodall has been deprived of the assistance of his fellow-worker, Dr. John Wichenford Washbourn, but the work still remains as a monument to the wide-clinical experience and clear judgment of his former colleague. In the present edition chapters have been added dealing with "Plague," "Cerebro-Spinal Fever," and "Glanders," and in other ways the book has been revised in accordance with the advance in our knowledge of fevers in general. In its present condition the work forms an admirable text-book of the infectious fevers, in which the teaching is sound and clearly expressed. The illustrations add considerably to the usefulness of the book, and are very well reproduced, many of them being taken from photographs of actual

We congratulate Dr. Goodall on the result of his (a) "A Manual of Infectious Diseases." By E. W. Goodall, M.D. Lond. and J. W. Washbourn, M.D.Lond. Second Edition. Revised and Enlarged by E. W. Goodall. 8vo, pp. xii. and 426, and 33 Plates. London: H. K. Iewis. 1908.

labours, and feel that we may assure him that it will not be found unworthy of association with the name of his late colleague, Dr. Washbourn.

THE READING PATHOLOGICAL SOCIETY. (a) THE Reading Pathological Society was founded in July, 1841, and now enjoys the senior position as regards age of the various pathological societies of England. The Pathological Society of Dublin was founded some three years before, but in 1882 it ceased to have an independent existence, being then merged in the Royal Academy of Medicine in Ireland as the Pathological Section. Though in the year 1898 the two medical societies of Reading, the Pathological and the Medico-Chirurgical, united, still the former society seems to have been able to preserve in the union its identity. Perhaps no branch of medicine has undergone more development during the past seventy years than that of pathology, and the history of this years than that of pathology, and the history of this development, as chronicled in the minutes of the Society before us, makes most interesting reading. It seems strange to think that at this Society, little more than sixty years ago, the view could have been held that fever, cholera, and typhus had one origin, and were "merely modifications of the same poison, the effects depending on the dose and the peculiarity of constitution, habits, etc., of the individual." We regret that Dr. Hurry has not enlarged more on the story of this development, and given us more of the individual views of the members of his Society. The volume, as presented, will be, no doubt, of great interest to members of the Society but it makes little more than a dry catalogue for the general reader. The short biographical notices of some of the members are the most interesting part of the book, and this more especially as they were mostly the ordinary workmen of our profession, those whose record is so interesting, yet so soon lost. The book is illustrated by many portraits, which are very well reproduced. We must congratulate the Society in having its annals presented in such an attractive dress.

#### NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publication of our last monthly list:—

EDWARD ARNOLD (London).

Further Advances in Physiology. Edited by Leonard Hill, M.B., F.R.S. Pp. 440. Price 15s. net.

The Sanitary Officer's Handbook of Practical Hygiene. By C. F. Wanhill, Major, R.A.M.C., M.R.C.S.Eng., L.R.C.P.Loud., D.P.H., and W. W. O. Beveridge, D.S.O., Major, R.A.M.C., 5s. net.

M.B., C.M.Edin., D.P.H.Cambridge, D.S.O., Major, R.A.M.C., M.B., C.M.Edin., D.P.H.Cambridge, F.C.S. Pp. 150. Price 5s. net.

BALLIERE, TINDALL AND COX (London).
The After Treatment of Operations: A Manual for Practitioners and House Surgeons. By P. Lockhart Mummery, F.R.C.S.Eng., B.A., M.B., B.C.Cantab. Third Edition. Illustrated. Pp. 251. Price 5s. net.
High Frequency Currents: Their Production, Physical Properties, Physiological Effects, and Therapeutical Uses. By H. Evelyn Crook, M.D., B.S.Lond., F.R.C.S.Eng. Second Edition. Illustrated. Pp. 232. Price 7s. 6d. net.
The Re-education of Self-Control in the Treatment of the Morphia Habit. By Oscar Jennings, M.D.Paris. Pp. 31. Price 1s. net.

John Bale, Sons and Danielsson. Ltd. (London).
The Medico-Chirurgical Series. No. 1. The Practice of Amesthetics. By Rowland W. Collum, L.R.C.P.Lond., M.R.C.S.Eng. General Surgical Technique. By H. M. W. Gray, M.B., C.M.Aberd., F.R.C.S.Edin. Edited by James Cantile M.A., M.B., C.M.Aberd., F.R.C.S.Eng. Pp. 382. Price 10s. net.
How to Cut the Drug Bill. By G. Herbert Hart, M.D. Pp. 47. Price 2s. 6d.
Polydore Barnes Co. (New York).
Medical and Surgical Report of the Presbyterian Hospital in the City of New York. Vol. 8, December, 1908. Edited by John S. Thacken, M.D., George Woolsey, M.D. Pp. 371.

Cassell And Co., Ltd. (London).
The Open-Air Treatment of Pulmonary Tuberculosis. By F. W. Burton-Fanning, M.D.Cantab, F.R.C.P.Lond. Second Edition. Pp. 184. Price 5s.

Crouxchill, J. and A. (London).

CRUZERILL, J. and A. (London).

A Manual of Minor Surgery and Bandaging (Heath). 14th
Edition. By Bitton Pollard, F.R.C.S. Illustrated. Pp. 485.
Price 7-, 6d net.

Text-Book of Nervous Diseases and Psychiatry. By Chas. L.

Dans, A.M., M.D., LL.D. Seventh Edition. Illustrated. Pp. 782. Price 25s. net.
St. Thomas's Hospital Reports. New Series. Edited by Dr. H.G. Turney and Mr. W. H. Battle. Pp. 390. Price 2s. 6d.

net.

School Athletics and Boys' Raoses. By Wm. Collier, M.D., F.R.C.P. Issued by the Medical Officers of Schools' Association. Pp. 32. Price Is. net.
CREMATION SOCIETY OF ENGLAND (London).
Cremation in Great Britain. 1909. First Edition. Pp. 96. I rice 6d.
JOHN CURRIE (Edinburgh).
The Pocket Prescriber. My James Burnet, M.A., M.D., M.R.C.P. Eng. Pp. 98. Price Is. net.
HENRY FROWDE AND HODDER AND STOUGHTON (London).
Oxford Medical Publications. Medical Inspection of Schools. By A. H. Hogarth, M.B., B.Ch.Oxon., D.P.H. Pp. 350. Price 6s. net.
G. GILLIES AND Co. (Glasgow).

Oxford Medical Publications. Medical Inspection of Schools. By A. H. Hogarth, M.B., B.Ch.Oxon., D.P.H. Pp. 360. Price 6s. net.

G. GILLIES AND CO. (Glasgow).

The Practical Medicine Scries. Edited by G. P. Head, M.D. Vol. II. General Surgery. Edited by J. B. Murphy, A.M., M.D. Series 1993. Illustrated. Pp. 617. Price 8s.

WM. GREEN AND Sons (Edinburgh).

A Practical Treatise on Diseases in Children. By Bustace Smith, M.D. Third Edition. Pp. 833. Price 21s. net.

CHARLES GRIFFIN AND CO., LTD. (London).

Foods: Their Composition and Analysis. A Manual for the Use of Analytical Chemists and others. By Alexander Wynter Blyth, M.R.CS., F.I.C., F.C.S., etc., and Meredith Wynter Blyth, B.A. Cantab., B.Sc. Lond, F.I.C., F.C.S., etc. Sixth Edition. Thoroughly revised, Enlarged and Be-written. Pp. 619. Price 21s.

HAMMOND, HAMMOND AND CO. (London).

Children of the Poor. Descriptions of their Life: the Possible Means of Improving the Conditions under which they are Reared. By A. Davies Edwards, M.B., B.S. Lond, B.Sc., D.P.H., etc. Pp. 74. Price 1s. net.

H. K. LEWIS (London).

House-Drainage, Sewerage, and Sewage Disposal in Relation to Health. By Louis C. Parkes, M.D., D.P.H. Pp. 142. Price 2s. net.

LUNINGSTONE COLLEGE (Leyton).

Livingstone College Year Book, 1909. Pp. 109. Price 6d. LONDON PUBLICITY CO., LTD. (London).

20 Years of Life and How to Attain Them. By Charles Reinhardt, M.D. (A Treatise upon the Use of Lactic Fermeuts for the Frevention and Cure of Disease and the Prolongation of Life.) Pp. 50. Price 1s.

LONDANS, GREEN AND CO. (London).

The Mystery of Existence in the Light of an Optimistic Philosophy. By Charles Wicksteed Armstrong. Pp. 131. Price 2s. 6d. net.

MACHILLAN AND CO. LTD. (London)

A System of Medicine. By Many Writers. Edited by Sir Clifford Albutt, K.C.B., M.A., M.D., etc., etc., and Humphry Dary Rolleston, M.A., M.D., F.R.C.P. Vol. 5. Diseases of the Respiratory System; Disorders of the Blood. Pp. 369. Price 2s. net.

Severest Amemias: Their Infective Nature, Diagnosis, and Treatment.

25s. net.
Severest Anacmias: Their Infective Nature, Diagnosis, and
Treatment. By William Hunter, M.D.Edin. Vol. 1. With
Historical Schemes, Charts, and Plates. Pp. 226. Frice

Historical Schemes, Charts, and Plates. Pp. 226. Price 108. net Archives of the Middlesex Hospital. Vol. XIII. Seventh Report from the Cancer Research Laboratories. Edited for the Cancer Investigation Committee by W. S. Lazarus-Barlow, M.D., F.R.C.P. Huustrated. Pp. 208. METHUNN AND CO. (London).

Drugs and Drug Habit. By Harrington Sainsbury, M.D., F.R.C.P. Pp. 307. Price 7s. 6d. net.

SHAW AND SCNS (London). Symptoms and their Interpretation. By James Mackenzie, M.D., M.R.C.P. Pp. 297. Price 7s. 6d. net.

ALEX. THCM AND CO. (Dublin). LONGMANS, GREEN AND CO. (London). The Royal University of Ireland. The Calendar for the Year 1909. Pp. 743.

JOHN WRIGHT AND SONS, LID. (Bristol). Golden Rules of Dental Surgery. By Chas. W. Glassington, M.R.C.S., L.D.S.Edin. Third Edition. Fp. 72. Price 1s. Pye's Surgical Handicraft: A Manual of Surgical Manipulations. Minor Surgery, and other matters connected with the Work of House Surgeons and Surgical Dressers. Fifth Edition. Evised and largely Re-written. By W. H. Clayton-Greene, B.A., M.R. B.C.Cantab, F.R.C.S.Eng. Illustrated Pp. 592. Price 12s. 6d. net.

not. Arthritis Deformans: Comprising Rheumatoid Arthritis, Osteo-Arthritis and Spondylltis Deformans. By R. Liewellyn Jones, M.B.Lond. Illustrated. Pp. 365. Price 12s, 6d, net.

#### The Royal Society of Arts Conversazione.

The annual and very popular conversations will be held, by permission of the Trustees of the British Museum, in the galleries of the National History Museum, South Kensington, on Tuesday evening next. the 29th inst.

The reception, by Sir William H. White, K.C.B., F.R.S., Chairman, and the other members of the Council, will be held in the Central Hall from 9 to 10 p.m. All the rare and beautiful exhibits of the Natural History Museum will be on view. Concerts in varieties sections will be given, and light refreshments supplied to visitors free of cost.

<sup>(</sup>a) "A History of the Reading Pathological Society." By Jamieson R. Hurry, M.D. 8vo, pp. 179, with 10 Illustrations. London: John Bale, Sons, and Danielsson, Ltd. 1909.

#### News in Brief. MEDICAL

#### Trinity College, Dublin

During Trinity Term, 1909, the following candidates for the Diploma in Public Health passed the examinations indicated:—Part I.—Charles D. Myles. Part II.—Charles D. Myles and Dudley F. Torrens.

The following passed the Final Medical Examination, Part II., in Medicine:—Ralph T. St. J. Brooks and David Duff (passed on high marks), Thomas A. Hughes, Eric J. Powell, Victor B. Kyle, George E. Craig, Frederick A. Anderson, John W. Flood, Cecil P. Smyly Craig, Frederic Cecil P. Smyly.

#### An Unqualified Chemist.

WHILST investigating the death of a carpenter's baby, the Hackney Coroner, on the 12th inst., learnt of the existence of a chemist's shop kept by a lady. The baby had a cold, and the mother purchased medi-cine at the shop referred to.

Mrs. Mary Ann Brierley, of Wick Road, the widow of a carman and contractor, said she was the keeper of the chemist's shop. She was not really a chemist, but was "just as good as one, as she went up for her examination and just failed."

Continuing, witness said the business carried on was not really a chemist's, as she did not sell poisons. She did sell camphorated oil, but only in pennyworths, never in quantities to harm. Possibly she sold the medicines given to the baby—a cough mixture and ipecacuanha wine, because it was asked for.

The Coroner: Of course, if she prescribed or sold

poisons something could be done, but there is no law

to prevent a woman selling herbs or harmless drugs. Dr. Alfred Stanhope Dawson said death was due to broncho-pneumonia. Far from doing any good, ipe-cacuanha was one of the worst things to give. The Coroner (to Mrs. Brierley): You run a great

The Coroner (to Mrs. Brierley): You run a great risk in giving medicines to sick children, and in the next case I should advise you to recommend a doctor

The jury returned a verdict of "Death from natural

#### Dr. Bell Taylor's Will.

DR. BELL TAYLOR, of Nottingham, has by his will left £5,000 each to the British Union for the Abolition of Vivisection, the London Anti-Vivisection Society, the British Committee of the International Federation for the Abolition of the State Regulation of Vice, the National Anti-Vaccination League, and the Royal Society for the Prevention of Cruelty to Animals; the gift to the last named society is conditional on the society within three years (or such extended period as the executors may allow) procuring the passing of an Act limiting the load which any horse or other animal may be compelled to draw to a weight bearing a certain proportion to the weight of the animal. In the event of the condition not being fulfilled, the legacy shall fall into residue for distri-bution among the other four societies named in equal The testator also directed that all his animals and birds should be kept in comfort as long as they shall live. The estate is of the gross value of £160,000, the net personalty being over £95,000.

#### The "Sanitas" Company.

At the annual meeting of this company, held at their works, at Limehouse, on the 16th inst., Mr. C. T. Kingzett, F.I.C., F.C.S., in the chair, attention was directed to some experiments lately carried out by certain bacteriologists accentuating the value of Sanitas Fluid as a disinfectant and air-purifier as applied by spray in school and living rooms. Great improvements had also been made with respect to certain other "Sanitas" manufactures, notably the Company's Patent Drain Testers and the two new Disinfectant Fluids known as "Sanitas-Bactox" (homogeneous) and "Sanitas-Okol" (an emulsion), both of which are now being manufactured and sold for commercial employment with a guaranteed strength at least twenty times that of pure carbolic acid, and which are available for use whenever disinfectants of high germicidal power are called for. There had been a satisfactory increase in the business of the company,. the chairman remarked, and the sales of the universally well-known "Sanitas Fluid," for sick-room and domestic applications, showed a very gratifying increase. A dividend at the rate of 7½ per cent: wasdeclared.

#### Sanitary Inspectors' Conference.

THE North-Western Centre of the Sanitary Inspectors' Association held a meeting at Southport on June: 12th. There were 120 members present from the counties of Lancashire, Cheshire, Westmoreland, and

counties of Lancashire, Cheshire, Westmoreland, and Cumberland, and a civic reception and tea were given by the Mayor. In the afternoon the members visited the Southport sewage works at Crossens.

Mr. J. T. Quinton, hon. sec., reported that the membership had increased by 41 during the year.

Mr. Allan Kendall (Southport) read a paper on "Sanitary Administration," in the course of which he said that local authorities had other things than sanitary affairs to attend to and sometimes sanitation was tary affairs to attend to, and sometimes sanitation was. neglected in favour of gas works, tramways, and other undertakings. He urged the necessity of fixing the tenure our dertakings. He urged the necessity of fixing the tenure of sanitary inspectors' appointments, and claimed that the duties of a sanitary inspector should include the supervision of new buildings. On the question of milk supply he observed that many of the owners of farms were obstacles to a pure milk supply. British farmers could learn a lesson from South American farmers could learn a lesson from South Michael farmers who attended to the healthy breeding of stock, especially on the male side. He also urged better attention to building, and the re-establishment of the services of milk maids, who were disappearing. The bacteriologist's requirements for a pure milk supply were almost beyond attainment; machine milking being the only possible means of meeting their require-

#### Royal Infirmary Edinburgh.

Two years ago the surgical out-patient department of the Edinburgh Royal Infirmary was thoroughly reorganised, and new buildings provided for it, and the medical out-patient department has been entirely re-modelled during the past year. Considerable additions and alterations of an extensive nature have been made on the part of the building in which this department was previously housed, with a view to providing better accommodation and working facilities generally for the proper carrying on of this part of the Infirmary's work. The department is situated immediately adjoining the entrance to the medical hospital, to which it is directly connected. On either side of the waiting-room are provided dressing-rooms, with lavatory accommodation for males and females. These dressing-rooms communicate by means of two parallel corridors with a large demonstration-room, with raised benches and seats, to accommodate eighty students. There are a separate entrance and staircase to the outside by which students are admitted, thus obviating the necessity for any traffic through the main portion of the department. An examination-room for females is also provided, while adjoining the demonstration-room is a private room for the physicians, and a dark room for the treatment of eye cases. A new exit has been formed, through which patients, after treatment, leave the building without having to return through the waiting-room. The whole department has been fitted up in accordance with the most approved. methods of hospital construction, and with a view to general cleanliness and convenience. A suite of rooms, consisting of a nurses' room, nurses' kitchen, and a lavatory, has also been provided, opening directly off the main vestibule. The department is warmed the main vestibule. The department is warmed throughout by steam-heated radiators, and where special ventilation is necessary an extract electrically-driven fan is provided. The walls of the various buildings are finished in polished Keene's cement, while in the waiting-room, vestibule, and corridors there is a dado of glazed tile. The floors in the waiting-room and corridors are of markle terrazzo, and ing-room and corridors are of marble terrazzo, and in the dressing-rooms and demonstration-rooms of red wood bedded in bitumen on concrete. The cost has been £3,000.

#### NOTICES TO CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much. confusion will be spared by attention to this rule.

#### SUBSCRIPTIONS.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January lat and July 1st respectively. Terms per annum, 21s.; post free at home cr abroad. Foreign subscriptions must be paid in advance. For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Bs 15.12. Messrs. Dawson and Sons are our special agents for Canada.

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ADVERTISEMENTS.

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Contributors are kindly requested to send their communica-

CONTRIBUTORS are kindly requested to send their communica-tions, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

B. S. (Surbiton).—We know of no rule to the contrary. On general grounds we should say the course you propose is not only absolutely safe, but perfectly straightforward and honourable. It may reasure you, however, to write explaining the circumstances to the Secretary of the Medical Defence Union, 4 Trafaigur Square, London, W.

Hospital Secretaity.—We have heard the name of the medical man you mention. His name was, if we mittake not, removed from the \*Register\* some years ago. You will never see your money again, and may congratulate yourself you did not cash the cheque as requested.

Quercus.—We will inquire into the matter, and communicate with our correspondent by letter.

Dr. Septimus.—Our correspondent will do well to bear in mind that exception probat regulam.

T. D. S.—If the offence should be repeated, notice should certainly be taken of it, either by a private remonstrance, or through the medium of a solicitor's letter.

Mr. D. B.—The bond, as it appears to be in order, should undoubtedly be enforced.

EXPERIENTIA DOCET.—A medical man who sends a patient to a consultant has obviously nothing to do with the payment of the tee of the latter. If payment is not made, either at the time, or subsequently, the consultant, after acquainting the medical man of the fact, should proceed direct to claim it from the patient, and, if necessary, through a solicitor. A patient who coluntarily incurs the expense of a consultant advice is alone responsible for the payment of it, and to him the consultant must look for the discharge of the fee.

Mr. TOM Barron.—We are unable to prescribe for the public in these columns. If you will consult your medical adviser on the matter, he will be able to help you.

### Meetings of the Societies, Tectures, &c.

WEDNESDAY, JUNE 23RD.

MEDICAL GRADDATES COLLEGE AND POLICITING (22 Chenies treet, W.C.).—4 p.m.: Mr. L. Mummery: Clinique (Surgical).

15 p.m.: Lecture: Dr. A. E. Giles: The Diagnosis of Pelvic

THERDAY, INEC 24TH.

ROYAL SOCIETY OF MEDICINE (SECTION FOR THE STUDY OF DISFASE IN CHILDREN) (20 Hanover Square, W.).—Wightman Lecture: Dr. George Carpenter: Congenital Heart Affections. ROYAL Society of Medicine (Section For The Study (20, Hanover Square, W.).—8.30 p.m.: Dr. James Collier and Dr. Gordon Holmes: Amyotonia Congenita: (1) The Pathological Findings in a Case previously shown before the Section; (2) Demonstration of a Firither Case with the results of a Biopsy. Dr. Albert Wilson: A Critical Description of the Brain of a Degenerate (a Convict and a Murdener).

ROYAL COLLEGE OF PHYSICALNS OF LONDON (Pall Mall East).—5 p.m.: Dr. W. S. Lezatus-Barlow: Radioactivity and Carchoma an Experimental Empary). (Croonian Lectures.)

Medical Graduates College and Politicinic (22 Chenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture: Dr. T. Hyslop: Paralysis and Insanity.

Insanity.

FRIDAT, JUNE 25TH.

WEST LONDON MEDICO-CHIEURGHEAL SOCIETY (Kensington Town Hall).—8.15 p.m.: Sir Victor Horsley: The Cerebellum. (Cavendish Lecture.)

ROTAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Fields, W.C.)—5 p.m.: Dr. G. E. Smith: The Evolution of the Brain. (Arris and Gale Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. St. Clair Thomson: Clinique (Ear, Nose, and Throat.
CENTRAL LONDON THEOAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 pm.: Lecture: Mr. Stuart-Low: Accessory

#### Appointments.

BREMRIDGE, RICHARD H., B.Sc., M.B., B.Ch.Oxon., L.B.C.P.Lond., M.R.C.S., Chief Medical Inspector of Schools for the county of Wilts.

of Wilts.

EVAMS, DAVID ROBERT POWELL, M.R.C.S., L.R.C.P.Lond., L.S.A., Medical Officer to the North Wimbledon Cottage Hospital.

Hepburn, Malcolm L., M.D., B.S.Lond., F.R.C.S.Eng., Assistant Surgeon to the Gentral London Ophthalmic Hospital.

18aAc, Charles Leonard, M.B., M.R.C.S., Medical Referre under the Workmen's Compensation Act, 1906, for County Court Circuit, No. 30.

JEFFRETS, W. M., M.R.C.S., L.R.C.P.Lond., House Surgeon at University College Hospital.

Martin, Basil W., M.B., B.Ch.Aberd., Medical Officer to the Heading Dispinsary.

Planson, J. Sidnet, M.D.Cantab., Pathologist and Registrar to the East London Hospital for Children, Shadwell.

Sweeting, R. Deane, M.D.Dub., D.P.H.Dub., Examiner for the Conjoint Diploma in Public Health of the Royal College of Physicians and Surgeons of England.

Thomas, William Myrray, L.R.C.P.Lond., M.R.C.S., Medical Officer for the No. 6 District of the Bodmin (Cornwall) Union. Vosper, S., M.R.C.S., L.R.C.P.Lond., Medical Officer to the British Lyings-in Hospital.

WILLIAMS, RICHARD THOMAS, L.R.C.P. and S.Edin., L.F.P.S.Gla-C., Medical Referree under the Workmen's Compensation Act, 1895, for County Court Circuit No. 30. EVANS, DAVID ROBERT POWELL, M.R.C.S., L.R.C.P.Lond., L.S.A.,

#### Bacancies.

Guy's Hospital Medical School (University of London).—Douglas-Research Studentship. Salary, 2300 per annum. Applica-tions to the Treasurer, at the Superintendent's Office, Guy's

tions to the Treasurer, at the Superintendent's Omce, Guy's Hospita'.

Egyptian Government—Ministry of Education.—Professor of Anatomy at the School of Medicine, Cairo Salary, £800.

Applications to "The Director, Egyptian Government School of Medicine, care of the Director, Imperial Institute, South Kensington, London, S.W."

Sheffield Union Hospital.—Resident Assistant Medical Officer. Salary, £100 per annum, with apartments, rations, and the other usual allowances. Applications to Albert Edw.d. Booker. Clerk to the Guardians, Union Offices, Sheffield.

Liverpool Parish.—Assistant Medical Officer. Salary £100 per annum, with rations. Applications to H. J. Hagger, Vestry Olerk, Parish Offices, Liverpool.

Canterbury Borough Asylum, Canterbury.—Assistant Medical Officer. Salary £140 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

Officer. Salary £140 per annum, what to be decided Superining, and attendance. Applications to the Medical Superintendent.

Manchester University.—Junior Demonstrator in Physiology. Salary £100 per annum. Applications to the Registrar. Bethlem Hospital.—Resident House Physician. Honorarium of £25 per quarter. Applications to the Treasurer, Brideaci: Hospital. New Bridge Street, £C. (See advt.)

The Hospital for Sick Children, Great Ormond Street, London. W.C.—A House Physician. Salary £30. washing allowance £2 10s., and board and residence in the Hospital. Applications to the Secretary. (See advt.)

#### Births.

HEPHTRN.—On June 14th, at Pevensey, Enfield, Middlesex, the wife of Malcolan L. Hepburn, M.D., F.R.C.S., of 66, Wimp Street, W., of a son.

SALAMAN.—On June 15th, at Homestall, Barley, Herts, the wife of Redeliffe N. Salaman, M.D., J.P., of a daughter.

WALLIS.—On June 17th, at 65 Cariton Road, Worksop, the w. sof A. Ransome Wallis, M.D., of a son.

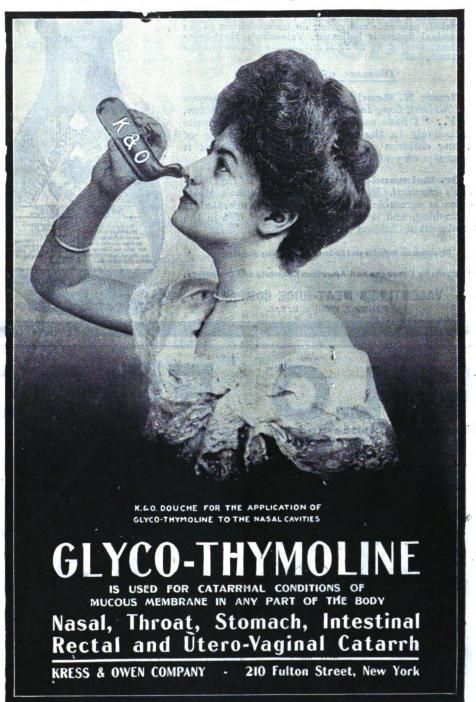
# Marriages.

ADDISCN—BROWN.—On June 18th, at St. Morylebone Parish Church, York Gate, Regent's Park, by the Rev. W. D. Morrison, Oswald Lacy Addison, F.R.C.S., of 55a Welbeck Street, London, son of Joseph Addison, of 20 Harley House Regent's Park, and Bond Court, Walbrook, London, and Kate (Cissie) Brown, M.B., B.S.Lond., daughter of Harold Brown, of 9 Chester Terrace, Regent's Park, and Bond Court, Walbrook, London.

SANDILAND—HILL—On June 19th, at St. James', West Hampstead, Digby Saver, elder son of A. H. Sandiland, LRCP., MR.C.S., and Mrs. Sandiland, of Oskley House, Cauonbury, to Lola, only daughter of Mr, and Mrs. Charles A. C. Hill, of West Hampstead.

#### Beaths.

ALEXANDER.—On June 17th, at Lyndhurst, Leigh, Essex, Samuel Alexander, L.R.C.P. and S. Edin, late of Bow, aged 53, ELLIOT.—On June 18th, suddenly, Frederick William Ethort, M.D., of 34 Bedford Square, Brighton.



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It is a Food with Milk as a basis.



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is much appreciated by nursing Mothers, and is invaluable at the time of weaning.

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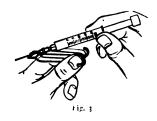


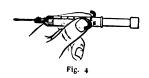


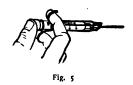
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Figs. 3, 4 and 5 show method of attaching and using the 'Tabloid'
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The constringent action of Adrenalin provides an almost bloodless field of operation, intensifies and prolongs the analgesic effect of cocaine, eucaine, etc., and diminishes their toxicity by retarding their diffusion, whilst its cardiac-stimulant action tends to guard against systemic ill-effects.

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Cocaine hydrochloride (2 per cent.) and Adrena'in chloride (1 in 15,000) in physiological sodium chloride solution preserved with Chloretone.

"Codrenine" rapidly induces effective analgesia and ischæmia.

The amount of cocaine injected can be regulated to a nicety—ten minims contain one-fifth of a grain.

"Codrenine" does not deteriorate if the bottle is kept well stoppered and in a cool, dark place.

"Parke, Davis & Co. have a very convenient solution under the name of 'Codrenine.' Two friends of mine have used it extensively and are pleased with it."—Brit. Dent. Journ., Sept. 16, 1907, art. "Local Anæsthesia in Dentistry."



### "EUDRENINE."

Eucaine hydrochloride (1 per cent.) and Adrenalin chloride (1 in 30,000) in physiological sodium chloride solution preserved with Chloretone.

"Eudrenine" acts somewhat less rapidly than "Codrenine" does.

It is preferred by some, as eucaine is less toxic than cocaine and nearly its equal in analgesic power.

"Eudrenine" may be sterilised by boiling, without detriment to its analgesic properties.

"I have used for some time, and found extremely useful, a preparation made by Parke, Davis & Co. under the name of 'Eudrenine'."—Brit. Med. Journ., Oct. 21, 1905, art. "Tracheotomy under Local Anæsthesia."

ADRENALIN AND COCAINE Hypodermic Tablets, B, "A" (P., D. & Co., No. 151).

Each contains :-

Adrenalin ... ... 1-300 grain. Cocaine Hydrochloride 1-6 grain.

The solution of one tablet in 18 minims of distilled water will contain 1% of the cocaine salt.

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Adrenalin ... ... 1-400 grain. Cocaine Hydrochloride 3-4 grain.

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Hypodermic Tablets
(P., D. & Co.).

Each contains:

Adrenalin ... ... 1-2000 grain.
Eucaine Lactate ... 1-6 grain.
Sodium Chloride 3-5 grain.

The solution of one tablet in 18 minims of distilled water will contain 1% of the eucaine salt.

Prices and further particulars of these preparations, also a brochure on "Local Analgesia," which details some of the operations in which it has been successfully employed, and indicates various methods of inducing it, will be sent on request by

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# THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVIII,

WEDNESDAY, JUNE 30, 1909.

No. 26.

# Notes and Comments.

Birthday Honours. The list of Birthday Honours announced last week is long enough to satisfy the most undistinguished of people who see in these periodical lists the only chance of marking

themselves as superior to their contemporaries. Nevertheless, as if by happy accident, among the mass of mediocre politicians and dutiful officials whose names figure in the list, there are to be found rari nantes some persons of real eminence and distinction. To these occurrences may be attributed the fact that the lists still maintain a semblance of interest outside the ranks of the Under immediately interested and their friends. our political system it is necessary to provide the Government of the day with a means of throwing sops to faithful adherents who do not embarrass them by overmuch speaking in the House of Commons, or who have helped the party cause without attaining unenviable notoriety. Our one grumble with the present Government is that they show a tendency to depreciate what should be a real distinction, namely, membership of the Privy Council, by swearing-in too many minor politicians, whilst fobbing off men who have done eminent service to the State with knighthoods and baronetcies. Huxley always held that a Privy Councillorship was the only proper recognition to be awarded by the State to scientific men, and he so far prevailed that, after refusing the Knight Commandership of the Bath several times, he was himself sworn-in of the Council. That act of Lord Salisbury's was regarded as creating a healthy precedent in the case of scientists who had achieved distinction; but, alas! it remains a solitary precedent to this day.

Wanted—
Some Privy
Some Privy
as a proper reward for scientists.
Councillors.
Both in themselves are barren
honours, and carry with them no
change in style in the ordinary address, though
the former gives members precedence at Court
before the younger sons of peers, a fact
which is not likely to lead the holders to
any giddy heights of exhilaration. We would
suggest to the Government, however, that as
the Privy Council, in theory, is the body which
guides the deliberations of His Majesty in the
regulation of the State, its ranks not only should
contain a good sprinkling of scientific and medical
men, but that such a class would add lustre to a
distinction which is now being rather rapidly
watered down by its too-frequent conferment on

persons of no outstanding intellectual attainments. We should like, too, to see the honour reserved for

men of real scientific eminence, and not given merely to physicians and surgeons who happen through some turn of the wheel of fortune to be in the public eye at the moment. We cannot imagine that even the present Privy Councillors would find much cause for discontent if their ranks were swelled by the presence of men of such worldwide fame as, for instance, Sir Clifford Allbutt, Sir William Gowers, Sir T. D. Fraser, Sir Victor Horsley, Professor Ronald Ross, Sir Thomas Oliver, and others in England, in Scotland, and in Ireland whose names will readily occur to our readers. For our part, we should be much more envious of those who are privileged to be called "Right Honourable" if those gentlemen held seats in the Council-room.

As things are at present, however, we must admit-and we do so The ungrudgingly—that the medical pro-fession is far more generously treated than of yore in the matter Present Recipients. of honours, and we fancy that one influence at work is that of the King, who has always shown himself appreciative of the work of a body of men to whom he owes so much himself. If His Majesty's happy recovery from his severe attack of typhoid fever cannot be specially attributed to medical skill—it is always difficult to prove a claim of that kind in the case of specific fevers—the excellent result which followed his fracture of the patella and the astonishing success which attended his operation for perityphlitis cannot but be largely attributed to the surgical skill which was exhibited by his attendants. These facts, we are sure, do not escape the notice and memory of a monarch who never forgets an old friend and never shows himself lacking in gratitude for services rendered. Beyond the official and military distinctions conferred last week, we have baronetcies awarded to Mr. Henry Morris and Sir Dyce Duckworth, and a knighthood to Lieut.-Colonel Leishman. In Sir Henry's case the honour is long over-due, as a baronetcy should be offered to the Presidents of the Royal College of Physicians and Surgeons in their year of office, whereas Sir Henry Morris has had to do the "hat-trick" in his post before it has come to him. We have frequently had occasion to criticise the College of Surgeons and the line taken by its representative on the General Medical Council, but we the more gladly acknowledge the leading position in the surgical profession held by Sir Henry, and we are sure that his pioneer work in renal surgery has not only won him recognition from the whole world, but will send his name down to posterity with those of Hunter and Bell. Since he received his knighthood nearly a quarter of a century ago, the name of Sir Dyce Duckworth has been almost a household word, and his recognition abroad as one of the representatives of British clinical medicine makes his present distinction all the more appropriate. Colonel Leishman's knighthood is particularly pleasing in view of the fact that it is due wholly and solely to his scientific work—and of what immense value that work is, scientists in every Continent know. Of the many brilliant men in the band of researchers in tropical bacteriology and pathology, none is more brilliant than the new knight. To all three gentlemen we offer our hearty congratulations.

Sacco's Latest Fast. In the Hanley County Court, last week, Dr. W. T. Brand brought an action against two men who acted as agents for Sacco during a fast lately undertaken by that celebrity,

to recover five guineas, the balance of a bill for medical attendance on Sacco during the fast. We have always been a little suspicious of these advertised fasts, but in evidence Dr. Brand stated that he himself was responsible for the bulletins and for the number of bottles of soda-water drunk and cigarettes smoked by Sacco. We therefore are led to conclude that Dr. Brand is responsible also for the genuineness of the performance, and we shall in future have a more comfortable feeling when we read of these fasts, if relieved of the sensation that there is no hanky-panky about them. genuineness is further confirmed by the fact that Sacco was very ill during the last few days of his confinement, which is not indeed surprising if he had had no food for nearly six weeks. The wonder is that he lived to complete his self-imposed task. The report before us is not very clear as to what was the substance of the defence put forward, but we rather gather that the medical attendance was denied, or cut down, because Dr. Brand could not do anything to Sacco because he was shut up in a glass case for his performance! We can imagine that it is difficult to treat a case through such a barrier, but clearly, if a medical man is sent for to attend a patient and to take the responsibility as to his condition, his work is not lessened-rather greatly increased—by having no means of access to him. The judge, we are glad to say, took the same common-sense view and gave judgment for Dr. Brand's claim.

#### LEADING ARTICLES.

# THE CONTROL OF UNQUALIFIED PRACTICE.

The success that has followed the efforts of the British Dental Association to put a stop to irregular dental practice may well encourage the medical profession to fresh endeavours in a similar direction. As the result of a series of successful prosecutions, the unqualified person who even remotely implies that he is entitled to practise dentistry is liable to condign penalties. In a word, the quack dentist, to use a homely phrase, is dead as a door nail. As we all know, it is only within comparatively recent years that the Dental Acts were passed legalising the profession, rendering proper qualification obligatory, and imposing penalties upon a practice. On the other

hand, the medical profession has possessed penal powers of a stringent nature ever since the days of King Henry VIII. In spite of those powers, which have been confirmed, strengthened and extended by subsequent Acts down to the Medical Act of 1858, quack medical practice of every kind is still rampant throughout the length and breadth of the United Kingdom, and the penal provisions of the Medical Acts are so readily evaded, that "false practitioners," as they were called in King Henry's day, simply snap their fingers at the law. The section of the Medical Act intended to restrain these rogues has been interpreted so that nowadays any unqualified person may practice medicine without let or hindrance, provided he does not call himself "doctor." Were this section to be applied by magistrates with anything approaching the rigorous way in which they have maintained the corresponding principle in the Dental Act, the days of the medical quack would be speedily numbered. Why the dental pirate should be ruthlessly exterminated while the far more dangerous pseudomedical brigand is allowed to carry on his nefarious pillage unchecked is a profound mystery. power to do harm is in the one case limited almost entirely to the mutilation of teeth and jaws, while in the other instance it may, and often does, inflict an incalculable amount of damage upon the health and life of the community. The failure of four hundred years of legislation to remove so great an injury to the public weal is remarkable in various ways. The fault certainly does not lie in the laws themselves, for however loosely-worded in places, they nevertheless, by expressly confirming the powers of King Henry's Act, reiterate again and again the principle that the people must be protected against false medical practice. To some extent the blame may rest upon too lenient an interpretation and administration of statutory powers. Yet in the long run it may be doubted whether the medical profession is not mainly responsible for the growth and the continuance of this unclean thing. By the creation of duly qualified medical practitioners a monopoly in conferring qualification was conferred upon a certain body of men in London, and it was expressly enacted that they were in turn to exercise special control over quacks and quackery. The privileges have been retained, but the duties have been permitted to lapse, and, later, were imposed upon the General Medical Council only so far as the discipline of qualified practitioners was concerned. But what have the qualifying bodies, the colleges, the universities and the halls done to protect their alumni and the public against false medical practice, and what are they doing at the present moment in return for the enormously valuable privileges conferred upon them by the legislature? That question may be answered by the brief statement, that in the past they have done nothing, or next to nothing, and at the present moment are doing nothing whatever by way of recompense to the State from whom they have received their privileges, or to the medical men from whom they have received their pelf. Can any single instance be quoted in which any college, university or other medical qualifying body has petitioned the State with a view to the suppression of unqualified practice? Has the General Medical

Council ever brought its enormous influence to bear upon the Privy Council in a similar direction? The latter body has attempted to justify itself by a plea of non possumus, but had the Council been elective and really representative of the medical profession, we venture to say that it would long ago have obtained from Parliament the necessary powers for the protection of the public and of medical men against false or unqualified practice. Why should not the colleges and universities petition the Council and the State for the conferring or the re-enacting and strengthening of penal powers that are urgently needed in the best interests of the community? The root of the evil may undoubtedly to a great extent be found in the fact that all, or nearly all, the qualifying bodies are close corporations governed by a small knot of privileged men, to whom the chartered body is everything and the diplomate or graduate nothing. In the reforms that one day must overtake the medical profession, a prominent place must assuredly be given to the transference of government to constituent graduates and diplomates of all degrees. We have long advocated a Royal Commission upon quacks and quackery, but a necessary corollary will be an inquiry into the way in which the qualifying bodies have discharged their statutory obligations in the control of these offences. Some way out of the present intolerable state of affairs with regard to unqualified medical practice must be found, and we cannot avoid the conclusion that medical men would find the strongest and best friend in their own right hand, if only they took up the matter with wholehearted and collective enthusiasm.

#### CURRENT TOPICS.

# Sickness Insurance and the Medical Profession.

We recently took occasion to warn Mr. Lloyd George that if he institutes the system of compulsory sickness insurance, which he hopes to bring forward next year, without due consultation with the medical profession, he is almost certain to create a situation which will be unworkable. We know that the Chancellor of the Exchequer has been making inquiries in many directions, and we believe from what has been announced that the system will be an excellent one in theory. It is all the more imperative that it shall not break down in practice. Such a scheme will touch the profession at many points, and it is necessary that its details shall be discussed with accredited representatives of the medical profession if it is to be just and successful. Mr. Lloyd George has shown himself so accessible to bodies interested in his other schemes, both when he was at the Board of Trade and since he was raised to his present important office, that we believe the matter has only to be brought to his notice for him to realise the necessity of it. Naturally, the Government wish to make their system as cheap as possible, but that desideratum may easily lead to a loss of efficiency, if not complete breakdown. In Germany a new scheme of insurance for the working-class is being introduced under which medical men will have to give their services almost gratuitously, and the doctors are organising a movement to refuse to attend insured patients if the proposals become law. We are not in possession of sufficient detail to be able to express an opinion on the justice or advisability of this course, but we do know from precedents at home and abroad that it is usual to look upon the doctor as the willing beast of burden for all Government schemes that cost money. It is far better that the profession should be consulted before Mr. Lloyd George's proposals see light than that they should find it necessary to oppose them when they are brought forward, and we beg the Chancellor of the Exchequer and his advisers to take heed in time.

#### Two Epidemics.

An odd and interesting occurrence is reported from Saddleworth, namely, the co-existence at the moment of two epidemics. One of these is the harmless, necessary mumps, the other a much rarer one, namely, an outbreak of erythema nodosum. In the absence of precise details as to the number of persons affected and the distribution of the diseases, it is not possible to form any intelligible theory as to the origin of the two outbreaks, or as to whether there is any connection between them. The medical officer of health has said that there is no connection between the occurrence and any of the local industries, and it is also remarkable that none of the adjacent districts are affected. epidemic of mumps has become so widespread already that one school has had to be closed, but otherwise the disease does not appear to exhibit any but ordinary features. That erythema nodosum, however, should occur in epidemic form is very uncommon, though not quite unprecedented. The symptoms which are said to be found in the present patients are sore throat, little if any fever, general pains, and the characteristic eruption of the legs and forearms. Some cases are complicated by pericarditis, tonsillitis, pleurisy and acute anæmia. The chief prophylactic measure advised by the sanitary authority is the gargling of the throat and mouth with disinfectants. Doubtless in time we shall have a report on the subject, and we hope that it may be possible to trace the outbreak to its source—a matter which should not be so difficult in the case of erythema nodosum as in that of the common infectious diseases, which, owing to their widespread prevalence and easy distribution, frequently baffle the most lynx-eyed of medical detectives.

#### Vicious Children.

We have never been able to make up our minds definitely as to Dr. Rentoul's scheme for the sterilisation of degenerates. Theoretically, it is monstrous that inveterate criminals and lunatics should be allowed to propagate and reproduce in their young those anti-social qualities which have made their own lives a curse and entailed much misery and expense to the community. On the other hand, it is optimistic in the extreme to think that society will accept the rational method of prevent-

ing reproduction which Dr. Rentoul proposes. If any additional argument were needed for the necessity of action of some kind it is to be found in Dr. Kerr's Report to the Education Committee of the London County Council. Leaving aside the physical defects, we may turn to some examples of moral degradation which he sets forth. There are recounted tales of children of ungovernable temper, destructive outbursts, and murderous tendencies. "Manslaughter has been committed by children of innocent, pleasant, and in one case of angelic appearance." The cherub in question was so far oblivious of moral obligations as to try to drown another child; another little terror flung the baby across the room, and a third "probably" drowned a companion. One child of nine killed a cat with his hands and it required four people to take him to school, whilst another of like kidney and the same age set fire to his parents' house. Nearly all the children in this class were relatives of drunkards. imbeciles or lunatics, and Dr. Kerr opines that these morally defective youngsters require to be taught by regular and inflexible corporal punishment. No doubt the rod should frequently be taken out of pickle for these wretched children's benefit, and often has a salutary effect in the milder cases, but many have no future as men and women but that taken by their degenerate relatives, and it is grave, perhaps the gravest, moral question as to whether they should ever have been allowed to be born.

The Daylight Saving Bill.

AMONG recent witnesses before the Parliamentary Committee on the Daylight Saving Bill was Sir Thomas Barlow, who, speaking, according to the newspapers, from the medical point of view, gave his blessing to the Bill. The most natural mode of living would be to use as much of the hours of sunlight as possible, leaving the hours of darkness for rest. The limiting of working hours to the hours of daylight would, by doing away with the use of artificial light, do much to safeguard the eyesight of workers. In these pronouncements, of course, every sensible man, whether lay or medical, will agree. We would very much like to see a general agreement to make our active diurnal period coincide more closely with the hours of daylight, but we do not think that the habits of a nation are to be changed by tampering with clocks. The proposal in the Bill, indeed, seems to us so impracticable, that we have been surprised to see that quite a number of otherwise level-headed people are supporting it. It should not go forth, however, that because Sir Thomas Barlow favours the Bill, authoritative medical opinion is with him and endorses the method proposed.

#### Identification by Veins.

A NEW suggestion of some interest and importance in the science of criminology has been made by Dr. Tomassia with regard to identification. Briefly summarised, his plan is that identification can be better established by the disposition of the veins of the back of the hand than by any other method, and his suggestion is that a bandage

having been tied tightly round the wrist in order to render the veins prominent, a photograph should be taken of the back of the hand. The present system, of course, is identification by means of finger-prints, a system invented by Colonel Henry. elaborated by Professor Galton, and generally The chief argument ascribed to M. Bertillon. advanced by Dr. Tomassia is that it is almost impossible for a criminal of whose veins the police have a record to destroy the marks of identification by artificial means. It is said that at present criminals whose finger-prints are recorded can mystify the police by defacing their fingertips either by cutting the pads of the fingers with knives, or of burning off the epidermis and thus creating new lines. We doubt if either of thus creating new lines. these practices is really established, but, at the same time, there can be no harm in adopting Dr. Tomassia's plan as corroborative evidence if it is sufficiently systematised to render trustworthy evidence. That it can supersede identification by finger-marks as a general system we do not believe for a moment, for, apart from the specific value-already generally admitted-of the disposition of the whorls, so sure is the finger-print system that over and over again criminals have been identified and brought to justice solely by means of impressions of the pads of their fingers left on doors, glasses and other objects in the room where the crime has been committed. However specific the venous system of identification is, it could never give this evidence, though as corroborative evidence we can conceive of its being of great importance.

#### Inebriate Reformatories.

THERE is no question but that Mr. Ritchie's plan of inebriate reformatories has in practice broken down. We do not say that as any reproach to a Home Secretary who, by his gifts and influence, was able to initiate a system strongly opposed by that large section of the community which holds that a man (or woman) has a right to get drunk as often as he likes, if he does not cause a nuisance to hisneighbours. Rather should we use this breakdown as an argument for still further extension of the system and for granting still further powers to those in charge of reformatories. Magistrates are doubtless, as a class, high-minded gentlemen, but their idea of drunkenness is mainly confined to the imposition of a five-shilling fine, with or without option. Of the disease, inebriety, they know as little as they do of dementia præcox or general paralysis of the insane. Their training gives them as little insight into pathological problems as it does into the intricacies of building an aeroplane. The one cardinal factor which stands out at the moment is that the control of reformatories and the detention of inmates should be under the supervision of expert medical men, in exactly the same way as the control of lunatic asylums is at present. From north, south, east and west we hear that reformatories are expensive and do littleer no good. We reply, What good would lunatic asylums, fever hospitals, or other essentially medical. institutions do if their inmates were sent by magistrates' orders for a period of definite detention, irrespective of their malady or the treatment needed? We trust the Government will find an early opportunity of pushing forward legislation on the lines recommended by the Royal Commission on the Feeble-minded and the Departmental Committee on Inebriety.

The Preservation of Dead Bodies.

For various medico-legal purposes it is clearly of advantage to have at disposal some simple, yet efficient, means of preserving dead bodies. So far as medical men are concerned, a process of the kind would rob the post-mortem room of much of its unpleasantness, and, in all probability, of not a little of its attendant risks. Then, again, in the case of coroners' juries and of persons called upon to view bodies for purposes of identification, the use of a refrigerating or preservative apparatus constitutes an unspeakable boon. Our attention has been drawn to an excellent apparatus which has been established in the City of London mortuary. It is made on the système de Richter plan, widely adopted on the Continent, and obtainable from the English agents, Messrs. T. Christy and Co., Swan Lane, London, E.C. The body is placed on a metal litter in a large rectangular box, furnished with windows of glass through which the body can be seen. The box is filled with an evaporation chamber containing cloths kept constantly moist with formaldehyde. By means of a small electric motor the vapour from the antiseptic drug is kept circulating round the body, with the consequence that the processes of putrefaction are quickly and completely arrested. The many advantages of this method are so obvious that there is no need to detail them to our readers. The chief wonder is that something of the kind has not been long ago introduced into all mortuaries in which large numbers of bodies are habitually lodged.

#### Burial of the Dublin Poor.

DURING the past few weeks there has been much discussion in Dublin with regard to the management of the large cemeteries adjacent to the city. It is alleged that the fees charged for the purchase of plots and opening of graves are extortionate, and though the charges for the burial of the poor are not complained of, yet it is alleged that the circumstances under which such burials take place are such as to constitute a scandal, if not, indeed, a danger to the public health. At a meeting of the Corporation, at which the matter was discussed, one of the speakers stated that in the part of Glasnevin Cemetery reserved for the poor, there existed a large pit in which the coffins were placed side by side and in tiers until the pit was full. It was stated that coffins might thus lie unburied for days or weeks, and that at times a very unpleasant odour was observed. If the condition of affairs is as described, we can hardly believe that the sanitary authorities would not ere now have intervened. A rather unfortunate result of the discussion is that the entirely irrelevant subject of the provision of bodies for dissection has been dragged in. At the Dublin Boards of Guardians debates are pending as to the conditions under which the

guardians will permit bodies of inmates to go to the medical schools for dissection. On many occasions, when ultra-sentimental guardians have endeavoured to place difficulties in the way of medical education, the Boards have shown their common-sense by declining to listen, and we hope they may continue the same enlightened policy.

#### PERSONAL.

On the 24th inst., the King and Queen attended the dedication services of the Memorial Chapel at the Queen Alexandra Military Hospital, Millbank.

It is anticipated that the King, who goes to Manchester on July 6th to open the new Infirmary buildings, will also visit the University in that city.

Dr. G. RICHELOT will preside over the twenty-second Congress of the French Surgical Association, to be held in Paris in October.

Dr. Septimus Barnett presided at the fifty-fourth annual dinner of the West Kent Medico-Chirurgical Society on June 18th.

Dr. W. T. CLAY, of Holyhead, has been placed by the Lord Chancellor on the Commission of the Peace for the County of Anglesea.

PROFESSOR LANDOUZY, Dean of the Faculty of Medicine of Paris, will preside at the annual meeting of the French Association for the Advancement of Science, to be held at Lille in the first week in August.

MAJOR J. ROBERTSON REID, M.D., R.A.M.C. (T.), has been selected as an Honorary Associate of the Order of St. John of Jerusalem in England, in recognition of his good work in connection with ambulances.

AMONG the recipients of Birthday Honours are Mr. Henry Morris, thrice President of the Royal College of Surgeons, England, and Sir Dyce Duckworth, Consulting Physican to St. Bartholomew's Hospital, both of whom receive baronetcies.

Another recognition of good work which will be popular to the profession is the conferment of the dignity of a Knight-Bachelor on Lieutenant-Colonel Leishman, Professor of Pathology at the Royal Army Medical College, Millbank.

In addition to the names already mentioned for the Chair of Surgery of Aberdeen University, it is understood that a further candidate is Dr. D. M. Greig, Dundee, Lecturer on Clinical Surgery in St. Andrews University.

At Leuchars, on June 19th, Dr. John Constable, who is retiring from practice, after the long period of 46 years, was presented by a few private friends with a handsome silver salver and a large purse of sovereigns.

MR. SIMEON SNELL, F.R.C.S., of Moor Lodge, Sheffield, Professor of Ophthalmic Surgery at University College, Sheffield, who died on April 17th, aged 57, left estate of the gross value of £30,451, with net personalty £26,883.

SURGEON-GENERAL EVATT, C.B., will preside at the annual dinner of the Poor-law Medical Officers' Association at the Waldorf Hotel on July 6th. The Honorary Secretary of the Association is Dr. Major Greenwood. The Lord Mayor and Lady Mayoress have invited members and their wives to tea at the Mansion House in the afternoon.

### A CLINICAL LECTURE

ON THE

#### CLINICAL EXAMINATION OF SPINAL CASES. (a)

By J. JACKSON CLARKE, M.B. Lond., F.R.C.S.,

Senior Surgeon to the Hampstead and N.W. London Hospital, and Surgeon to the Royal National Orthopædic Hospital.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

LADIES AND GENTLEMEN,—I have chosen for to-day's conversation a subject which has been regularly before me during the last 14 years, that is to say, the clinical examination of spinal cases.

Our first mental act when confronted with a spinal affection is to recall the natural form and mobility of the spine. We know that in the fully flexed position the human spine makes an unbroken C-shaped curve. In the extended position it also makes a C-shaped curve, but not quite such a smooth one, because the extension movement in the cervical and lumbar regions is greater than it is in the dorsal region. The lateral flexibility of the rotation movements must also be kept in mind. When we first see a patient with the view of ascertaining the condition of the spine, we must always be on the look-out for any péculiarity of attitude which the patient assumes, especially when he is not aware that we are watching him. I need only mention the stiff neck of a child with cervical disease, who often supports the head with the hands, that the elbows resting on the chest; or the manner in which a patient with lumbar disease picks up any object from the floor. For inspection of the spine, when the patients are not too ill to sit up, I prefer to have them on a firm level stool in front of a window, preferably one looking northward, with good diffuse daylight, the feet comfortably resting on the floor or on a firm footstool.

Let us take congenital abnormalities first. All the different forms of spina bifida are congenital malformations of the spinal column, and even the slight degree known as spina bifida occulta, when examined by the Röntgen rays, will often be found to be associated with a large defect of bone in the sacral region. Another congenital deformity of the spine is Sprengel's deformity, or congenital elevation of the shoulder. I show you the skiagram of a patient who came to me some years ago, and had been treated by being kept on her back for two or three years, on the supposition that she had lateral curvature. Her lateral curvature was born with her, and could never have been any different. The scapular muscles are also affected in these cases. In another case I had, the diagnosis was made by the schoolmaster. He diagnosis was made by the schoolmaster. He told the class to hold up their hands, and this boy could not get his above the shoulder, and he had a caning for obstinacy; and that led to the condition being recognised. Notice how much the spine is deviated laterally, and the curious deformities there are in the ribs in this condition of congenital elevation of the shoulder. I saw that young lady ten years ago for the first time, and told her there was nothing to be done except to make the best of things. She has not got any worse since then.

Another congenital affection of the spine, which I

Another congenital affection of the spine, which I have illustrated here, is a slight degree of that which, when severe leads to the formation of an anencephalus. I have no doubt this, like so many congenital deformities, is caused by a deficiency of liquor annii at a certain period of development. In such a fœtus the head is pressed down on the chest; there is no brain, and the spinal canal is open from skull to sacrum. In a lesser degree the head is bound down rigidly on to the chest; I show two examples of the condition. Here the brain and spinal cord

Let us pass now to cases where there is a history of some traumatism. When we are told a person has had a fall and ricked the neck, we always have to very seriously consider the possibilities. It is not uncom-nion in connection with head injuries to hear of a patient going to hospital and being sent home with a few stitches in his scalp, and being found dead in bed next morning. That is not so common in spinal injury, next morning. That is not so common in spinal injury, but it happens now and again that a person who has had what he looks on as a slight "crick" has really suffered diastasis, that is, a momentary dislocation or fracture, which has righted itself, but on some fresh sudden movement it may return, and this time with pressure on the spine, with possibly fatal results. So here the importance of X-rays in the diagnosis of spinel conditions comes in Have in the diagnosis of spinal conditions comes in. Have the patient very carefully moved, and see whether there is a temporary fracture or dislocation, or a mix-ture of the two. Another class of traumatic spinal cases are those of spinal neurasthenia. Amongst these are included cases of "railway spine": and both have as their special symptom, spinal irritation. I have as their special symptom, spinal irritation. I have seen strong men who have had an accident, and suffered from spinal irritation for months afterwards. We see it also in women whose nervous systems have been overtaxed. This spinal irritation and hyperæsthesia of the skin on each side of the spine is often so great that the least touch with the fingers is agony, and the slight pressure touch with the fingers is agony, and the slight pressure of the clothes is too great. In such cases some relief is afforded by applying an instrument which presses firmly where it does touch, and yet keep the patient's clothes away from the body. The causation of spinal irritability in spinal neurasthenia I am a little uncertain of, because it is not limted to the neurotc type of case. I have seen it, but only in rare cases, in severe tubercular disease of the spinal column of children, otherwise free from any nervous symptoms; in one such case it was very marked and only very gradually disappeared in the course of years during the progress of the case. Thus we cannot dismiss this symptom of spinal neurasthenia as being always unassociated with organic changes.

That brings me to another type of case, in which there is considerable irritability in the spine, tender

That brings me to another type of case, in which there is considerable irritability in the spine, tender spots, pain in the back, generally about the middle, associated with patches of anæsthesia in the feet or legs. Some might be inclined to include those among cases of spinal anæsthesia, but I regard them as toxic.

are not affected. One feels that there is a defect of vertebral arches, and both these patients a lady, at. about 20, and a boy, at. 4—were singularly intelligent people. The lady was too far grown up for operative treatment; but in the boy, by dividing the sternomastoid muscles, I was able to make him a neck, as shown in this picture. Those conditions are worth studying, because that operation has made a great difference in the boy's position in his family; he can now look straight before him, instead of appearing to be perpetually searching the ground. I believe this was the first time that condition had been so treated. In him I examined to feel the condition of the sternomastoids before operation, but the head was so much down on the chest, that until I had made incisions I could not tell whether the sterno-mastoids were present or not. So the clinical examination in that case was completed under an anæsthetic and through an incision.

<sup>&#</sup>x27; (a) Delivered at the Polyolinic Chemies Street, W.C., on Thursday, June 19th, 1909.

They are generally associated with long-standing constipation; and a three or four weeks' course of regular clearing-out of the bowels by enemata and aperients such as cascara, combined with massage of the spine, will clear up the whole condition permanently. From such a history that of spinal neurasthenia is different, as a rule, for when we succeed in getting a good result in this latter it has usually been a matter of months, not weeks. I consider it a toxic condition, leading to certain spinal nerve root vascular changes.

I would also mention hysterical affections of the spine, and those we see among people with exhausted nerves. The worst case I saw was in a woman who for many years suffered from lichen planus, which is a very torturing affection, and often difficult to make any impression upon. The marked lateral curvature in that case I found it very difficult to affect. In some cases good feeding and wholesome surroundings will put matters right.

When examining a patient, we have to keep our anatomy, physiology, and pathology clearly before us. Disease, of course, means some pathological process, and therefore I shall deal with the remaining condi-

tions under pathological headings.

Take a group of inflammatory spinal cases: acute infective osteomyelitis, that form of pyæmia which affects the bones, occurs in the spine sometimes, but I have seen only one case of it out of many thousands of spinal cases. Still, it must be borne in mind. The general and local symptoms are severe pain. If it is in the cervical region or the lumbar region we may find pus in the usual places, in front of the spine. If it is in the dorsal region, pus is not so readily found on exploration, but by the simple method I have on exploration, but by the simple method I nave employed, of just taking out the tip of the transverse process and part of a rib, even in the dorsal region, we may easily find if pus is present on the sides of the bodies of the vertebræ. In some cases I have seen, tuberculosis has been so rapid that I was in doubt whether or not it was acute infective osteomyelitis, the tip to can whether a characterise and acute the second s that is to say, whether a streptococcus or staphylococcus was at work, and not the tubercle bacillus. But on putting the patient to bed and treating her, the condition slowed down, and proved to be tuberculous.

Acute rheumatism sometimes affects the spine, but not often; so do gonorrheal pyæmia and other acute infections. The symptomatic pain in the back of fevers such as small-pox are to be remembered; here local examination would fail to reveal anything; and a doctor who is on the look-out for exanthems will soon recognise what may be going to happen, and watch for an eruption.

Next chronic inflammatory affections and new growths. Many of these are familiar: tubercle, rickets, osteoarthritis, typhoid, and chronic gonor-rhœal lesions, actinomycosis, sarcoma, carcinoma, hydatids. I shall deal with a few of these in detail.

Some years ago there was described in Continental literature a condition called Rhisomelic Spondylosis, meaning a chronic inflammatory affection of the spinal column with the root joints, that is to say, shoulders and hips. It is generally recognised that this is only one variation of rheumatoid arthritis, and it is such a rare condition that I have seen only one instance of it in 14 years.

Now comes a large group of cases of antero-pos-terior and lateral deviations of the spine, lateral cur-vature or scoliosis included. The ordinary round shoulders of the weakly modern, of any age whether from adenoids, or novel-reading, or whatever type it may be—is only too familiar to us. It is also known as excurvation of the spine. Dorsal kyphosis is the more scientific appellation. It is very often associated with undue hollowness in the lumbar region that is to say, dorsal kyphosis and lumbar lordosis often go together, and they are frequently combined with scoliosis.

Lateral Curvature.—When we recognise lateral curvature of the spine in a patient, it is not sufficient to diagnose scoliosis; we must give an anatomical and pathological diagnosis, and an idea of the stage of the affection. Take an ordinary type; convexity to the right in the dorsal, to the left in the lumbar region:

this we speak of as right dorsal-, left lumbar-convex scoliosis: or instead of there being two or more curves scoiosis: or instead or there being two or more curves there may be a single one, and then it should be described as a total left- or right-convex scoliosis, as the case may be. Then the pathological diagnosis. Many of these cases are simply the result of general weakness from a lack of fresh air and outdoor exercise and unhabits, babits, and most of them are associated with healthy habits, and most of them are associated with some pathology, if it is only anæmia; many of them with a definite pathology of rickets, many from an inherited a definite pathology of fickets, many from an innersted tendency to arthritic deviations from normal nutrition, which we need not particularise beyond that. They tend to be irritable in temper, and sometimes show it during examination; they have an excess of urates in their excreta, and so forth. You may require to very carefully ascertain what is the best form of courselment for them, and give planty of it. While nourishment for them, and give plenty of it. While speaking of scoliosis I would say you must be very careful not to make mistakes. I had one poor girl brought to me three years ago for a lumbar scoliosis, low down. There was something unusual about the appearance of it, some thickening of the tissues over the outer part of the ileum. A skiagraph helped us, and showed a large sarcoma, involving the bones. Previously the diagnosis had been merely scoliosis. Another case, which I described some years ago, I have seen for the last ten years. She had been treated for scoliosis, and held one shoulder very high. But examination showed it to be quite fixed. On feeling round the borders of it I found there was some thickening under it. Incision under an anæsthetic showed it to be a thick white growth adherent to the ventral surface of the scapula, under the ribs. Microscopical examination showed a very dense fibroma, such as are met with at the base of the skull, and lead to a frog-faced appearance. We removed as much as we could. It went into the thorax, and could not all be got away. For months it spread slowly up alongside the neck, causing. by pressure on nerve roots, great pain. Aspirin came into use about then, and I tried it. It stopped the pain as long as the patient took it, but the pain returned when she did not take it. The growth began to diminish in size, and finally disappeared. It left her with a stiff scapula, but there is no more growth or pain. I have watched her for several years, and it is still well. It is possible that this fibroma has been cured by the aspirin.

Another condition mistaken for scoliosis I also described at the Clinical Society. It was a contracted rectus abdominis, which had pulled the child round on one side, causing definite lumbar kyphosis and scoliosis. By dividing the rectus muscle that scoliosis was cured. So there again it was not an affection of the spinal column, but a deviation depending on one solitary muscle. Many cases of wry-neck are mistaken for scoliosis; they do cause scoliosis, but that is only a secondary condition-what may be called symptomatic scoliosis.

We must notice whether lateral deviation is masked by rotation. To do that we make the patient bend down, and then we look horizontally along the back. In a patient whose furrow is straight, we may see one part of the posterior thorax is higher than the other. That means that the lateral deviation has been masked by rotation. This rotation is nearly always towards the side of the convexity, and therefor it turns the spine in towards the concavity of the curve. Thus in the slighter cases of scoliosis the spine is straight, looked at from behind. But we must be on the look-out for scoliosis paradoxa, where the rotation is in the opposite direction.

In addition to the pathological causes of scoliosis which I have mentioned, there is cretinism which is being treated by thyroid extract. causes such improvement in nutrition that the patient shoots up like a forced plant, and the bones are not strong enough to bear the new weight, and begin to assume spiral forms. Deviation of the spine in such a case might, perhaps, be prevented by suitable treatment, including rest in bed.

There is a class of nerve diseases which cause scoliosis, and we must bear them in mind when we have what we take to be a case of simple scoliosis.

Tuberculosis is so familiar that I shall not say much

about it. X-rays are helpful in recognising it. Here about it. X-rays are helpful in recognising it. Here is one which shows marked destruction at the root of the neck and another in which a tubercular abscess was causing paraplegia. This other skiagram is very interesting to me, because there is not only a disc of darkness, but a darkness ensheathing the spine, showing tuberculosis spreading along the spine in the periosteum and ligaments. That was a paraplegia in which I trephined many years ago, and the lady is quite well at the present time. In these tubercular cases we look out for rigidity; but in early cases the rigidity is not complete, and we can often make a child with early tubercle bend down somewhat, when we shall notice a little break in the smoothness of the we shall notice a little break in the smoothness of the curve. In the rickety spine the bend takes place at the upper part of the lumbar region. These rickety cases are often very difficult to distinguish from the tubercular, and when in doubt we have to treat them as if for tuberculosis. Luckily, it is good for both; rest is good for a rickety spine, and it is necessary for a tubercular spine. Girdle pain, etc., must be looked for, and the sign of early psoas abscess, namely, a slight bending at the hip-joint.

In adults there is no more important nerve sign that I know than Babinski's reflex: stroking the sole of the foot and getting a marked extension of the great toe. That is a very important sign of organic disease of the spinal cord. We get it in early cases of compression paraplegia from spinal disease. Spasticity of muscles, ankle clonus, etc., are expressions of slight degrees of the same compression which causes complete paresis

when it is more pronounced.

Next I would say a word about syringomyelia, which causes scoliosis. Yesterday I had a patient, a big girl, who, two years ago, became scoliotic. There is great weakness in the muscles of the hands, weakness especially in the legs, and also lateral curvature. On putting her on the couch and stroking each foot down, there was a tremendous Babinski reflex, so at once one said it was not an ordinary case of scoliosis; there is something organically wrong with the spinal cord. The history was that just before the onset of her lateral curvature she had what her mother called rheumatism in the neck, and her head was drawn back for many weeks. She has had posterior meningitis, and the foramen of Magendie was blocked by that, and there has followed dilatation of the central canal of the spinal cord, causing syringomyelia. Recently Dr. Sutherland asked me to see with him a case in order to decide whether we were dealing with tubercular spine, with pressure on the spinal column, or whether it was disseminated sclerosis. The man had a very marked spastic condition, and some little nystagmus and tremor in the hands, but no marked change in the speech. I could not tell until I had an X-ray picture taken, and then it was seen to be very like the picture I have shown you, with a shadow extending along the spinal column.

The next condition I would refer to is pain in the back, localised at one rib. I described this also at the Clinical Society some years ago, and last year, at the meeting of the British Medical Association a Belgian professor described it again as a new thing. It projection of the end of the 12th rib, Ît is a painful indeed, due to inflammation of joint, between the 12th rib and the vertebra. the removed the projecting outer portion of that rib, and removed the projecting outer portion of that he, and there has been no more trouble. The weakening of the ligament by the inflammation of the joint, and the pull of the muscles, caused that rib to project, and when the projecting portion was removed, there was no lever for the dress to work on and cause irritation of the joint. We have to be careful not to mistake osteo-arthritis of the spine to be careful not to mistake osteo-artifities of the spine itself or of that joint for ovarian pain, or any other pains in the back. One patient I have in hospital now had a combination of movable kidneys and osteo-arthritis of the spine. I gave her the benefit of the doubt to see whether osteo-arthritis of the spine accounted for her pain and other symptoms. I gave her a good rest in hed, but her troubles got worse: her a good rest in bed, but her troubles got worse; she began to vomit very much. So I had her in hospital, and fixed both her kidneys by double nephrorraphy. I saw one painful case, in which both ovaries

had been removed for pain in the back. It was due to rheumatoid arthritis, which, of course, was unin-

fluenced by the operation.

One last case I would bring to your notice: of a young woman who has a very pronounced lordosis. She could neither sit in comfort nor stand, and in lying down she had a sort of Marble Arch under her back, which was filled up with pillows. For some years I lost sight of her. Since then she has been to years 1 10st sight of net. Since that the benefit of some very skilled examinations, which excluded nervous disease. concluded that it was a primary lordosis, due to shrinkage of the erector spine muscles. When we attempted to straighten her back, the muscles became very tight on each side of the spine. So I prepared myself for an ample operation of elongating these muscles, but I thought I would first try simple subcutaneous section, and put a narrow scalpel in and divide the whole erector spinæ muscle. I was surprised to find there was no bleeding. It diminished her lordosis by half, and at a later operation I divided the same muscles a little higher, and the infraspinous ligaments, and her lordosis is almost gone now, as the patient lies in bed. This observation illustrates the value of continuous study of spines for a good number of years. When I first saw her I had not realised the fact that this patient's spine might be compared to a foot in a case of simple pes cavus, where there is no paralysis to account for it; but the fascia and the muscles have either not developed, or have shrunk, and I thought I would treat that lordosis in the same simple fashion as we treat pes cavus, and so far this line of treatment has succeeded as well as, or even better than, I expected. How far the improved form will be maintained remains to be seen.

Note.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Clinton T. Dent, F.R.C.S., Surgeon to St. George's Hospital, and to the Metropolitan Police Force. Subject: "Recent Experiences of Artificial Respiration,

#### ORIGINAL PAPERS.

#### ON DILATATIONS OF THE FEMALE URETHRA. (a)

By R. D. PUREFOY, M.D., F.R.C.S. Formerly Master of the Rotunda Hospital, Dublin.

THE structure and anatomical relations of the female urethra are such that in the ordinary conditions of life it is much exposed to traumatism, and to this many of its pathological conditions can be traced directly or indirectly. When we reflect on the pressure and stretching of the soft parts which attend parturition, even in easy deliveries, our only surprise will be that urethral trouble is not a more common sequel to child-bed. On the present occasion I desire to direct attention to dilatation of the urethra and its attendant complications in the lower, middle, and upper third of the canal. In the first-mentioned position it is so often associated with prolapse of the mucous membrane that it becomes difficult to say which condition originated first. It is, perhaps, less common here than in the middle or upper third, and is often due to some abnormal growth of the urethral lining, either some neoplasm or inflammatory swelling, or, if Baker Brown be right, associated with stone in the bladder. It is sometimes, unfortunately, a sequel to mechanical dilatation. Dr. Skeene records a very interesting case where there was marked dilatation of the lower end of the urethra, without any recognisable cause. The

(a) Bead in the Section of Obstetrics Royal Academy of Medicine in Ireland, May 21, 1908.

patient was an unmarried woman, æt. 35, who suffered from displacement of the uterus and cervical catarrh, but had no urinary trouble whatever. On making an examination it was observed that the orifice of the urethra was widely patulous and the lower third of the canal funnel-shaped. The mucous membrane was healthy, and the patient suffered no discomfort. It was not possible to ascertain any history affording an explanation of the origin of the trouble.

The symptoms in this form are less marked than in the other varieties, and as there is not necessarily any derangement of function, little discomfort may be experienced unless there be inflammation or ulceration, when urination will probably be frequent and painful.

An extreme degree of these associated conditions, prolapse and dilatation, was observable in a middle-aged married woman amongst my extern patients at the Adelaide Hospital some years ago. On separating the labia, what at first sight appeared to be the introitus vaginæ was found to be the enormously dilated urethral orifice, surrounded by a fringe of prolapsed mucous membrane. The finger readily entered the urethra for nearly an inch. There was no incontinence of urine, but a complaint was made of weakness and bearing down. The application of strong nitric acid brought about marked narrowing of the opening and corresponding relief to the discomfort. In this case I think it highly probable that coitus took place through the urethra.

Dilatation of the lower third of the urethra is also found in association with congenital absence of the vagina, in which case it is most probably due to coitus taking place into the urethral canal.

Two other alternative plans of treatment remain open to us—(1) The use of the actual cautery, using a pointed instrument applied in such fashion that strips of healthy mucous membrane may intervene between the cauterised surfaces, and thus obviate the risk of undue marrowing of the meatus; (2) the removal of redundant mucous membrane by knife or icissors and careful suturing with catgut.

Ulceration of the urethra in its lower third, attended with dilatation of the canal, is by no means common; but a case of great rarity and interest, illustrating these conditions, was admitted to the Rotunda Hospital under my care in the year 1901. The patient was an unmarried woman, aged about 33 years, and in bad health. So far as was known her mode of life made it highly probable that she was suffering from syphilis. On separating the labia the introitus vaginæ was with difficulty located, owing to the enormously dilated urethral orifice, everywhere showing a red granulating surface, in the midst of which a funnel-shaped depression marked the course of the urethra. It is very remarkable that in spite of this extensive structural change the woman did not suffer from incontinence of urine.

Dr. West, in his interesting "Clinical Lectures on Diseases of Women," gives an account of six cases, apparently identical with the one just mentioned, which came under his care. Two of these were married women, who acknowledged to having suffered from syphilis; the remaining four were of unchaste life, one of them at the time suffering from a secondary syphilitic eruption.

These patients alleged that they had experienced painful and difficult micturition for periods varying from nine months to five years. The ulceration appears to begin at the orifice of the urethra, and to extend thence inwards towards the bladder, producing as it extends a great widening of the canal and a patulous state of it orifice, so that the finger tip can enter it with ease, while the surface is the seat of large, firm, indolent granulations which secrete a muco-purulent fluid, and, though not very tender to the touch, are highly sensitive to the passage of urine. Dr. West observes:-"I have met with this ulceration of the urethra independent of any other disease of the sexual organs; but have also observed it associated with unhealthy ulceration of the clitoris and nymphæ, and also the posterior commissure of the labia and the entrance of the vagina. When the disease has been of long standing I have seen the lower wall of the urethra represented by a dense cartilaginous substance, not unlike one of the lips of a hypertrophied and procident cervix uteri, and on two occasions I have been able to carry my finger along the whole length of the canal into the bladder." "Whether these cases are truly syphilitic, or whether they deserve to be classed more properly with the rodent ulcer, or lupus exedens, I am at present unprepared to say. In their management combined local and constitutional treatment was generally followed by improvement, not absolute cure. The use of the actual cautery in one instance was productive of signal benefit."

My patient's history and probable mode of living rendered the diagnosis of syphilis highly probable; but her impatience of the restraints of hospital life prevented me from having her sufficiently long under treatment to effect any marked change in her miserable condition.

We proceed in the next place to consider dilatation of the middle third of the urethra, which is more common than that of any other portion of the canal. In this form the anterior wall of the canal maintains its normal position, but the posterior, being distended, settles down, so that in time the urethra, instead of being a slightlycurved canal, becomes triangular, the upperanterior wall being the base, and so a sac or cavity is formed. The constitutional symptoms arising from these urethral troubles are the same as those caused by urethritis, and are not peculiar to this class of affections, and a careful physical examination will be requisite in every case. A digital exploration of the vagina will reveal to us the size and consistence of the swelling, and a sound or catheter passed into the urethra simultaneously will enable us to ascertain the thickness of the abscess sac and at the same time differentiate between dilatation and hypertrophy. In the earlier stages of this affection the urethra in front and behind the pouch is really or apparently contracted, but in some cases of the kind the upper part of the canal and neck of the bladder become dislocated downward, and finally the upper portion of the urethra may also become dilated. That the middle portion of the canal should most frequently suffer in the way we are considering is easily explained by its position and relations. The hyperæmia which attends pregnancy and the increase of tissue in these parts will probably disappear very slowly—indeed, very incompletely—after a protracted labour, owing to imperfect involution; and a long series of pregnancies,

however successfully conducted, will inevitably be followed by structural changes here.

Bozeman, in writing on the pathology of this affection, points out that it is frequently preceded and caused by narrowing or stricture of the meatus. I think he has exaggerated the frequency of the last-named condition and its causal relation to the widening higher up. On the other hand, we know that the posterior wall is apt to be pushed downwards and contused, while the upper remains in its normal position. The relaxation caused by this over-stretching of the urethral wall forms a small pocket in the canal, which becomes gradually dilated more and more by the pressure of the urine till urethrocele is fully developed. This presents itself as a smooth, round swelling of the anterior vaginal wall, having a sharply circumscribed outline, generally presenting at the vaginal entrance, especially if the patient coughs or forces. Pressure on this swelling causes diminution in its size and a flow of pus from the meatus. The number and variety of terms applied to swellings which agree in having the clinical character just mentioned, furnish ample proof that authorities are still divided as to their ætiology; but I believe the history of their origin and causation already given will hold good in most instances, especially as I am not aware that the condition has been met in a nulliparous woman. At the same time, the possibility of an abscess occurring in one of the crypts in the floor of the urethra, or in one of the lacunæ of Morgagni, must be admitted. It will be well to remember that an ordinary cystocele or a vaginal cyst in the anterior wall closely simulates urethrocele.

Whatever be their origin we divide these swellings, for practical purposes, into two classes--viz. those in which the sac communicates with the urethra by a small opening, and, secondly, those in which the sac is more a pouch due to extensive yielding of the posterior urethral wall, and forming part of the canal itself. In the former class the swelling may be present for a long time without causing much discomfort or any disturbance of the urinary functions; in the latter class, even at an early stage, there will probably arise frequency of urination and difficulty in the act. As a consequence of the frequency and the straining efforts which attend it, the bladder is apt to become injuriously affected, hypertrophy of its walls is likely to follow, and possibly, cystitis due to extension of the urethral inflammation. The forcing and straining efforts made by some of these patients while urinating are even greater than the mechanical obstruction appears to account for. Possibly this is due to the accumulation of urine in the urethra, which excites extra reflex action in the bladder and urethra out of proportion to the existing obstruc-To cases of this nature—i.e., those in which the entire posterior wall of the urethra has become weakened and dilated—the term urethrocele should be restricted, while we reserve for the former class the terms "suburethral abscess," "abscess of the urethra vaginal septum," or "urethral diverticulum." The French gynæcologist, Huguier, is believed to have described this affection in 1847, but we are indebted to Mr. Hey, of Leeds, an English surgeon of much earlier date, for an accurate account of a case and its successful treatment by a method which will still be found one of the best we can employ for the purpose. m free incision of the sac, the application of an antiseptic to its lining and the subsequent plugging of the sac with iodoform gauze. Stitching the edges of the opening or removal of a small portion of the sac wall will help to secure free drainage. The dissection out of the sac is a difficult proceeding, certain to be attended with considerable bleeding and sometimes followed by a fistula. Before resorting to radical treatment, as just described, we may in some cases try the effect of dilating the urethra below the sac and secure its daily emptying by pressure, and washing out with any mild antiseptic. Success has sometimes followed these measures.

Von Winckel, writing in 1886, mentions a case in which the patient herself used to empty the sac by applying pressure frequently, and by combining this proceeding, with the assiduous application of lead lotion, brought about a cure. Several years ago, amongst the patients attending my dispensary at the Adelaide Hospital a young woman sought advice on account of pelvic pain and distress. Examination showed that she was three months pregnant, and that the discomfort was due to a swelling involving the anterior vaginal wall and urethra. On careful investigation, what appeared at first to be merely cystocele was found to be dilatation of the urethra such as we are considering. Unfortunately, as so often happens in the case of extern patients, I was unable to keep her under observation long enough to test the value of any mode of treatment. Recently I was more fortunate. A lady, early in her second pregnancy, came under my care, and when making a vaginal examination on account of some vesical trouble I observed a small, smooth swelling, which at the time I concluded was a vaginal cyst. Her confinement took place in the country, and some months afterwards, owing to greatly increased pain and discomfort, she again consulted me. The swelling had considerably increased in size, and now presented unmistakable evidence of being an abscess sac communicating with the urethra. I dilated the canal anterior to the swelling, washed out the sac daily for some weeks, and effected such improvement that I hoped cure would follow. In this I was disappointed; so, several months subsequently, I incised the sac (which a more careful examination showed me communicated with the urethra by a small opening), swabbed the cavity with carbolic acid, and plugged it with iodoform gauze, having previously stitched its edges to the vaginal mucousmembrane to prevent too rapid closure.

I understand from my patient, who has returned to the country, that there is still some escape of urine when she moves about much. Even if there be a small urethral fistula, I am not without hope that it may close without further operative measures.

Kelly mentions that in one of his cases a secondary operation for fistula became necessary.

Dilatation in the middle third of the urethra is sometimes associated with the presence of a calculus, as happened in the case of a young woman admitted under my care into the Adelaide Hospital some years ago. It was situated apparently in a diverticulum in the anterior wall of the urethra, and so much overlapped by the mucous membrane that it was quite possible to pass a sound or catheter into the bladder without detecting its presence. With some trouble, after dilatation of the canal, I extracted the calculus. In such a case there is room for speculation as to the origin

of the calculus, whether it is renal or vesical, or even urethral, and simply arrested on its way down; or, on the other hand, whether it is portion of a foreign body introduced from without.

Dilatation of the upper third of the urethra is probably in most instances a consequence of a partial prolapse of the bladder and upper end of the canal, caused originally by injury inflicted during parturition, when the tissues are in a hyperæmic and relaxed condition. The condition of prolapse allows an unusual pressure of the urine upon the upper end of the urethra, and dilatation is apt to follow. From whatever cause arising, dilatation in the upper third of the canal may, and often does, give rise to very distressing symptoms. In addition to the frequent or incessant desire to pass water, may be added partial incontinence during coughing, laughing, sneezing, the effort to lift anything, or in stepping from a height. Without constant attention to cleanliness and the use of some soothing healing application inflammation of the outer parts will probably be added to the other miseries. Fortunately, in many of these cases the mechanical support which can be secured by carefully adjusting a pessary will afford considerable relief.

Some days after I had concluded my paper I unexpectedly found in the "Obstetrical Transactions" for 1890 a communication by Dr. Routh, headed "Urethral Diverticula," which deals with somewhat the same subject, and gives many interesting details of the various recorded cases. as well as the methods of treatment recommended and practised, including his own. It is not a little strange that he leaves unnoticed Mr. Hey's contribution to the literature of this subject, which is probably the first, and certainly one of the best, papers dealing with the affection. I am glad to find that he concurs in my opinion as to restricting the term urethrocele to those cases in which we find merely a dilatation of the canal; though he is too dogmatic when he states that palliative treatment invariably fails. I agree with him in rejecting the opinion that Skeene's ducts should be regarded as the anterior terminations of Gaertner's canals.

# RONTGEN RAYS IN DISEASES OF THE STOMACH. (a)

By V. SCHMIEDEN, M.D., Professor of Medicine, University of Berlin.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

In November last I delivered an address with demonstrations on this subject, "The Röntgen Rays in Diseases of the Stomach."

It is my intention to communicate some special experiences on the subject made in another place, and in my address, therefore, I confined myself to schematic tables, to show the typical changes of form; then showing a number of plates, in which the diseases of the stomach that caused changes of form could be recognised; the material was divided into cases of gastroptosis, dilatation, carcinoma, and hour-glass stomach. In discussing the schematic figures, I could only with a few words touch upon the interesting question, what form and what position, when empty and when full, were the characteristics of the stomach, as well as in the various phases of digestion—a question to which Röntgen illumination has contributed im-

(a) From observations carried out in Professor Bier's Department of the Royal Surgical Klinik, University of Berlin. portant conclusions. There was not time to go into the importance of these conclusions as regarded general stomach diagnosis, nor into the method of examination, nor the natural limits with which it is hedged in. It was for me to show that to him who is able to look over a large field of observation, and who is able to control what he sees by operation, a surprising amount can be shown in the Röntgen figure, and very rapidly and plainly, quite independent of the question as to how much could have been discovered without the aid of the Röntgen rays.

In the discussion that took place, some speakers put forward the question whether any real advantage was to be hoped for from the procedure or not, so I am compelled to give expression to my own views on the point, as well as to make known the method of examination, which the shortness of time on the previous occasion did not allow. First of all, there are many more aids to the procedure than could be mentioned at the session of November 12th. I have only shown pictures obtained by dorso-ventral radiography in the upright position; 500 grm. of porridge were given previously (a smaller quantity in case the stomach was small) mixed with bismuth. The first taken was made immediately after filling the stomach; a second, or perhaps a third, from two to seven hours later. In this way it is shown, for example, that some hours after the filling of the stomach it was completely emptied by way of the pylorus, or that for twenty-four hours considerable portions of the bismuth mixture still remained in it. In this way important conclusions could be drawn, not permitted in so simple and decided a way by any other clinical method; the form and changes of position of the shadows were not only interesting, but also of high value. I here call to mind the changing and filling of the two halves of an hour-glass stomach, of which I have now made seven observations, and, above all, the clear images caused by remains of bismuth in the crater-like depressions of ulcerated carcinomata, and which could be seen there when all the other parts of the stomach were free. Such residua have sometimes given a better indication as to where the growth actually was, and how far it extended, than when the stomach was

In this connection the question may well be asked whether in the great majority of cases such a special diagnosis as to the site of the tumour is of much importance as regards therapeutics? No true critic can answer such a restricted question with a "Yes." We know that for the question, with a "Yes." We know that for the question, "Operation or not?" a much more general diagnosis is sufficient; yea, even that the experienced surgeon in many cases, when the history is known, can tell by even a little handling whether laparotomy must be performed or not. In such cases— and they are not a few—we can put into practice the whole of the apparatus of internal diagnosis, which consists in testing the residua of the stomach contents-the test breakfast, chemistry, examination of the stools, the constitution of the blood, and many other things. And in spite of this labour, in any well-ordered hospital a part of these diagnostic aids, at least, will be made use of, because every scientifically-working surgeon desires to secure himself against surprise, because he will keep his knowledge and action under control, and, not least, because we all know that these aids sometimes bring up unexpected information and clear up errors of diagnosis. Above all, then, a teaching institution must make this its standpoint.

But the above-named question, whether there is any value as to treatment, in the great majority of.

cases does not touch the central point of the matter. In the first place, a very accurate diagnosis must be striven for for its own sake, independent of any ponderable use in any given case; secondly, we must thankfully acknowledge that the Röntgen procedure has in individual cases given us certain conclusions when all other means have left us in the lurch. This is the case, for example, in the case of tumours that cannot be felt, that hide themselves under the liver, especially at the lesser curvature, and which sometimes cannot be demonstrated until it is too late for operation; or the high-seated hour-glass stomach, which every experienced surgeon knows is frequently only brought to light by the laparotomy itself. Such cases are known to other observers also, and in the discussion mentioned, Goldscheider related such a case that was not recognised until it was submitted to the Röntgen rays.

At the klinik at which the above-named studies were made, the greater part of the stomach cases were taken direct from the poliklinik, and only a small part from the hands of the intern specialists, who had already made thorough previous examinations. We are, therefore, thoroughly schooled in making use of all means of diagnosis, and are far removed from putting radiography in their place. In addition to the history of the patient, we make use of a diagrammatic sheet, in which all points for inquiry are scheduled. These embrace age, sex, occupation, history, as to pain, eructations, vomiting, hæmatemesis, emaciation, melæna, appetite, constipation, palpation, gaseous distension, examination of residua of food, trial breakfast and its chemical examination, condition of stools, Röntgen illumination, after giving bismuth and porridge.

This shows that in making use of the Röntgen process we do not dispense with other means of diagnosis; we use it for the purpose of completing, but not excluding.

I consider it unfortunate that the importance of radiography for diseases of the stomach, about which there can no longer be any doubt, is kept in the background by people saying that the practising surgeon has not always an X-ray apparatus at his command. If so, the Röntgen rays should not be used at all, and, more than that, on the same grounds, a large number of scientific aids would be excluded from the clinical laboratory, such as bacterial and serological diagnoses, and many others, as the practitioner has neither the time nor the special skill, nor the apparatus necessary for all these.

Along with the photography of the stomach, the direct view before the Röntgen screen is of great importance, from many points of view; greater than the plate figure. It is true that the illumination of a large corona cannot be carried out. With some practice, we see how the mouthful swallowed glides down before the eyes, forms itself to the shape of the stomach's interior, where it makes a halt, for example, at a contracted spot; we see also whether in the flaccid, atonic stomach it sinks at once into the deepest part of the greater curvature.

At the same sitting we can also see the gas bubbles that are always to be found at the fundus of the stomach, the form of which is of diagnostic value, and the size increased by taking an effer-vescing draught. The movements of respiration alter the position of the diaphragm and the abdominal contents; drawing-in of the abdomen acts in a similar manner. In certain forms of the stomach, or when adhesions are present, the bismuth law is sometimes pushed upwards,

sometimes downwards, and sometimes there is no change. At the greater curvature the eye sees the form and character of the peristalsis; the bismuth mixture may be pushed in any direction by the hand, towards the pylorus, the function and behaviour of which towards the stomach contents may be studied. In the address mentioned, examination in the dorsal or lateral position could be just as little touched upon as all this, and they are all methods for refining the diagnosis. There is also the combination of illumination with palpation of a tumour that can be felt, and its relation to the bismuth shadow.

With these short notices I would bring to your view the many-sidedness of the procedure. In difficult cases the most diverse ways are attempted to gain light on the diagnosis. Illumination most suitably follows an examination made with the screen; the image seen here is sketched with a fatty pencil and compared with that produced on the Röntgen plate.

As is known, our method of examination is not applicable to the stomach alone; the cesophagus and the intestinal canal are within certain limits accessible to it, and beautiful sharp contrasts arise in considering the deep shadow against the air-filled colon and the small intestine. It is possible for the practised eye to distinguish tumours of the stomach from those that belong to neighbouring organs, and which only affect the contour from without. It is just in these difficult cases that one learns to understand how foolish it would be to depend for a diagnosis in difficult cases on the Röntgen image alone. I designedly omit going into details here; these can only be discussed in connection with the individual case when we have the illustration before the eye.

Neither shall I go into the question of the technique employed in producing the illustrations shown at the meeting mentioned. For the coarse outlines of the stomach a time exposure is sufficient; for the more delicate contours the so-called flash pictures are best made use of (that is, exposures of about 4 seconds); they come out more sharply, as the movements of respiration and peristalsis do not blur the picture. In tumours attached to the abdominal wall or the pancreas, also, a time

exposure gives the sharpest picture.

It is perhaps too early to bring up the question as to whether the Röntgen light will be called upon to render the long-desired early diagnosis of cancer of the stomach possible, or, at least, to allow of more timely conclusions to be drawn. I hold the latter to be possible in individual cases; it will certainly be very useful. On the whole, however, one hopes at present in vain. I promise myself some advantage from the above-mentioned illustrations, in which the deposits of bismuth have remained in a suspicious spot in the stomach, whilst the remainder of the porridge has passed on. Attempts should repeatedly be made to get such a picture in a similar case, just as one recognises a renal calculus by a constant shadow by observations made on several days. This, however, would not unconditionally prevent confusion with ulcer of the stomach. The change of form produced by a commencing carcinoma would in many cases be exactly that produced by an ulcer, and we also have learnt by experience that a possible source of error lies here. It would lead astray, not to mention the deceptive images that will certainly make their appearance, especially in the case of the beginner. Since the introduction of the bismuth method, however, we have expected greater things, and more special diagnoses than formerly. This speaks more for the value of the method than for its uselessness. For reasons easy to be understood, the method has quite well-defined limits, as a portion of the diseases of the stomach are not attended by any characteristic change of form that can be represented by any means at our command at present. The Röntgen procedure is every year making such great strides that there is no ground for placing limits on what it can do. For the last six months I have applied myself to this method, and have examined about fifty cases; every case brings new original observations and advances our experience. It has already been of great practical use. We believe that surgery will reap the main advantage from it, as the true and the false figures can at once be controlled, and as the shadow figure often leads at once to the diseased part of the stomach without any lengthened search.

I would point out, in conclusion, that the clear plastic image allowed by the bismuth method makes it an excellent educational means for academic instruction.

THE

# PREVENTION AND TREATMENT OF DYSENTERY. (a)

By Lieut.-Colonel W. J. BUCHANAN, M.D., B.Ch.,

Inspector-General of Prisons, Bengal,

THE subject of the prevention and the treatment of dysentery is one of great importance. It is probably a more common disease in Bengal than in other parts of India, so much so that Norman Chevers, an acute observer, many years ago, applied the term "Morbus Bengalensis" to the chronic ulceration of the intestinal tract from which so many natives of Bengal die.

The successful prevention of dysentery must depend upon an accurate knowledge of its ætiology and method of spread. In typhoid the view has recently been taken that it is the sick or convalescing patient that is the danger, the "bacillus-carrier," and Capt. Forster has brilliantly applied this theory to dysentery. We have therefore been endeavouring to fight dysentery in Bengal gaols on these lines. The bacillus of Shiga or other allied bacilli are the causes. These organisms are shed by the convalescing or sick "carrier," and reach the intestinal tract of other persons in many ways.

I am, however, firmly convinced that the predisposing causes are of great importance, and they have the advantage that they are, to a considerable extent, controllable. Moreover, in considering such a disease in 'a gaol, asylum or school we must remember that a very considerable number of the inmates bring the disease with them from outside, and are therefore actual or potential "bacillus-carriers" from the moment of their admission.

The Predisposing Causes.—Among the predisposing causes must be counted the disturbance of the digestive tract caused by unsuitable fcod, or badly cooked food. The danger of badly-cooked food was forcibly impressed upon me some 17 years ago in Midnapore Gaol, where, after a violent cyclone had wrecked the kitchen, the prisoners' food that evening and the next morning was issued in a raw, half-cooked state and there was within the next few days a sudden outburst of dysentery and diarrhœa, 125 patients having been

admitted to hospital within a couple of days. On many other occasions, seeing a rise in the number of dysentery cases coming to hospital, I have directed attention to the cooking and almost always found something wrong. I am therefore firmly convinced that good cooking and well prepared clean food are important measures in the prevention of dysentery. Other predisposing causes are less direct, for example, previous illness, malaria, etc. Food, however, I am convinced is more important than water. It is a commonplace of hygiene to put down bad water as a cause of dysentery, and certain specific cases are always quoted. I have long held the following view (and it applies largely to typhoid also) which is that water if specifically polluted will carry the disease, and will account for a sudden outburst of dysentery or of typhoid, but such outburst will be short-lived and will cease or greatly lessen on changing the water or on destroying the virus by boiling, etc., but the water supply will not explain the persistence of a few cases of dysentery or of typhoid; and the supply of pure water will not get rid of these diseases, and that even where the greatest care is taken of the water. Even where it is carefully filtered in a Pasteur filter installation and distributed in pipes dysentery may still prevail.

The water-borne theory of typhoid conveyance has long been known to have broken down in India, and I have long come to the conclusion that elaborate care taken of the water in gaols is not the cause of the diminished incidence of dysentery, and that it has prevailed in gaols with a water supply above suspicion, and has not prevailed in gaols and at times when the Chemical Examiner could only classify the water as "suspicious," or at best "usable." It is very probable that the dysentery bacilli soon die in water. Another factor in the spread of dysentery in a gaol or an asylum is by means of soiled clothing and bedding. Capt. Forster's work at Midnapore shows that the Shiga bacillus has a short life outside the human body, and on clothing and on sheets the bacilli have been killed by exposure to the sun in a couple of hours.

Means of Prevention.—Once we get hold of the view that it is the convalescing or sick dysentery patient that is the danger and that for several weeks after apparent recovery he may be, and probably is still shedding the bacilli in his stools; it is not difficult to suggest means for prevention. The latrine, for example, may become an important factor in the spread of dysentery, and the use of the left-hand by natives of India for ablution is also an obvious source of infection and reinfection. The free use of dry earth by each prisoner is one safeguard, the burning of sulphur or cowdung to keep off flies is another precaution, as also is the use of kerosene in the limewash in latrines.

I need hardly go into further details, the main point is to recognise the principle that the sick or convalescing dysentery patient is himself the danger to others, and he should be looked after, especially as long as he is shedding bacilli in his excreta. Just as we are accustomed to look after and isolate convalescing small-pox or scarlatina patients while they are shedding the germs from the skin eruption. I do not say that it is easy even in a gaol, to carry out a full prophylaxis. Difficulties as to safe custody, work and discipline arise, but it is well worth persevering in the strict

isolation of these "bacillus-carriers," even at a temporary loss and with considerable difficulty. This method will certainly soon reduce the number, and the more thoroughly the method is persevered in, the more certain is the reduction in number, and consequently the less the difficulty.

The question of the new-comer remains. The population of a gaol is eminently a floating one, and about as many come in as pass out. Hence there is a constant stream of new-comers, many of whom are potential or actual "bacillus-carriers." We have not the means, it is needless to say, of conducting a bacteriological inquiry into the case of each new-comer, we must assume that all may be or are "bacillus-carriers," and make use of the seven to ten days of compulsory segregation to treat them with prophylactic doses of salts and perchloride of mercury, so as to get rid of as many as possible of the bacilli before the prisoners are allowed to mix in the general file.

I therefore advocate these measures of prevention as a convinced adherent of the view that sick and convalescing patients are the "bacillus-carriers," and are the danger especially to guard against, and I believe that once we grasp this essential fact it is not difficult to devise means of counteracting the evil influences. At first, no doubt, the action, necessitated by an acceptance of this view, is troublesome to enforce, but the more it is enforced the easier it becomes, and perseverance will certainly be rewarded.

#### OPERATING THEATRES.

ST. MARY'S HOSPITAL.

REMOVAL OF ANGIO-FIBROMA FROM LEFT VOCAL CORD.—Dr. WILLIAM HILL operated on a man, æt. 30, who had been sent up to the hospital by Dr. Baron, of Bristol, with a history of hoarseness of very long standing. There had been complete aphonia for five standing.

Chloroform having been administered, a direct vision laryngeal tube was inserted, and by this means the glottic region and the growth were brought into view at a distance of 6 or 7 inches from the eye of the observer. A straight pair of punch forceps were then introduced, and the growth, which was the size of a split marrowfat pea, completely removed by one manipulation of the instrument.

Dr. Hill pointed out that the removal of growths

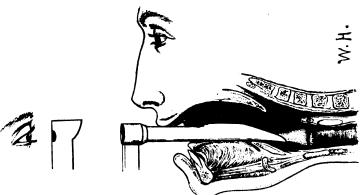


Diagram to show position of Brüning's laryngeal tube-spatula, with distal end in laryngeal vestibule, preparatory to removal of growth from vocal cord. For the sake of simplicity Brüning's hand-lamp is not shown.

in the near neighbourhood of the anterior commisure was always difficult under the old indirect mirror and forceps method, and often necessitated a large number of sittings to train the patient to toleration. All sorts

of difficulties, too, were encountered when the patient was over-sensitive and had no fortitude. With the was over-sensitive and had no fortitude. method he had just employed the patient comes into hospital one day with a growth, and minus a voice, and leaves the institution on the next day minus the growth and plus his voice. In expert hands, he said, the operation is performed without apparent difficulty, but it is not as easy as it looks to the spectator, as exactness in points of the technique of the operation is absolutely essential to success. He remarked that the direct method of operating on the larynx had been introduced by Kirstein twelve years ago, but had been little practised in this country till within the last year or two. During the preceding fifteen months, he said, a considerable number of endolaryngeal operations for the removal of growths had been performed in St. Mary's Hospital, but in no instance had the old indirect method been resorted to. Deep chloroform anæsthesia, he asserted, was essential, gas and ether being contraindicated on account of the spasm and congestion they caused. The operation is much facili-tated by painting the larynx with a solution of adrenaline and cocaine before the administration of the chloroform, and again previous to passing the instrument. In some instances the operation can be carried out entirely under cocaine anæsthesia alone. The chloroform should be administered by a skilled anæsthetist, as very deep anæsthesia is required to ensure perfect steadiness of the larynx and pharynx.

On the next day the patient quitted the hospital. His voice was then normal.

#### TRANSACTIONS OF SOCIETIES.

THE ROYAL SOCIETY OF MEDICINE.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD FRIDAY, MAY 28TH, 1909.

Mr. R. CLEMENT LUCAS in the Chair.

THE following resolution, sent up by the Council of the Section, was passed by the meeting:

"That, in the opinion of this Committee, it is desirable that the Board of Education should issue forthwith a complete set of forms for use in the medical inspection of elementary school children, in accordance with Circular No. 582, issued by the Board on January 23rd, 1908, and should issue definite instructions to medical officers as to the manner in which the medical inspection shall be carried out."

The following cases were shown:—
Dr. Porter Parkinson showed a child, æt. 4, with a large tumour on the left side of the abdomen extend-

ing to the iliac crest and nearly to the mid-line. The child had been healthy until a fortnight ago. Dr. Parkinson believed the mass to be a cystic malignant growth probably starting in the kidney.

Dr. F. LANGMEAD showed a case of

FACIAL IRRITABILITY OF FIFTEEN MONTHS' DURATION,

succeeding tetany, in association with dilatation of the large intestine. The girl æt. 8, was admitted to hospital for tetany in April, 1908. Her facial irritability was pronounced on both sides. No signs of organic nervous disease were found. The colon was dilated. Attacks of laryngismus stridulus occurred. The urine contained indican. The colon was daily washed out, whilst castor oil and salo! were given by the mouth. Sauerin,

koumiss, and thyroid were also used without effect. The washing out was discontinued, and energetic treatment with bismuth and opium applied. Enemata and massage were then used for a week with improvement, and after two months

she had gained 4 lb. in weight, and the tetany and laryngismus had subsided. The massage was continued for three months. The signs of dilatation of the colon then disappeared, but the facial irritability persisted. A month ago she had another attack of tetany with vomiting. Dr. Langmead referred to nine cases exhibiting relapsing tetany, dilated large intestine, and unhealthy offensive motions, occurring at an age beyond that of the usual infantile tetany. All had died except the patient exhibited. On tapping the cheek of the child an immediate rapid contraction of the muscles on the same side of the face was elicited.

Dr. ROBERT HUTCHISON asked whether the tetanic condition had ever been observed in congenital dilatation of the colon?

Dr. LANGMEAD replied that the question was

Dr. C. CARPENTER showed:—(1) A specimen of hypertrophic stenosis of the pylorus removed from a three-weeks old female child. The child was sick after taking the breast for the first time, and after every feed for a fortnight. A mixture of barley water and milk was used without success. The child when brought up was not in a fit condition for surgical operation. (2) A specimen of morbus cordis with complete transposition, including the liver, spleen, and large intestine, with a cyst in the tongue, and a solitary kidney. The condition was not diagnosed during life, and no symptoms were observed pointing to heart disease. The child became worse, and had fits two days before its death. (3) A specimen of congenital dilatation of the colon. This was from the colon of a child shown at the April meeting of the Section, at which the diagnosis had been questioned by some of the members.
The later history was that at the beginning of May she began to waste suddenly and quickly, losing 3 lb. 6 oz. in one week. Septic sores developed on the fingers. The bowels were opened regularly by cascara; the motions were of a pultaceous nature. As the infant became more and more wasted, the enlarged colon was readily seen through the thin abdominal wall, and contraction was easily excited by flipping with the The colon is about 17½ in. in length, and in. in circumference at the widest parts. The finger. The colon is about 17% in. in length, about 5 in. in circumference at the widest parts. dilatation begins at the ileocæcal valve, and ends abruptly at the beginning of the rectum. The mucous membrane shows no ulceration.

Dr. Spriggs said he was one of Dr. Carpenter's critics on the former occasion solely on the ground that the X-ray photograph was not, in his opinion, conclusive, and he was prepared to adhere to that view, though there was no doubt that the colon now produced was dilated.

Mr. CLINTON DENT gave a cinematograph demonstration of the movements of the stomach, as seen through the abdominal wall, in a case of

CONGENITAL HYPERTROPHIC STENOSIS OF THE PYLORUS.

The child was aged 8 weeks, and it weighed 8 lb. on birth, and 5 lb. on admission to hospital, 11 days before death. It was not considered safe to operate. The pylorus could be felt distinctly; gastric peristalsis was extremely marked and very easily excited. The cinematograph showed plainly the waves of contraction passing over the stomach. Mr. Dent said that the post-mortem examination showed the whole pyloric canal to be in a state of hypertrophy. The mucous folds were well marked, and, he had no doubt, were, as is usually the case, the final cause of the obstruction.

The CHAIRMAN expressed the indebtedness of the Section to Mr. Dent for his excellent demonstration.

Dr. ERIC PRITCHARD showed:—(1) A case of unilateral hypertrophy of the hand from macrocheiria in a boy, æt. 10. The left hand was observed to be larger than the right shortly after birth. A capillary nævus was also noticed to extend in an irregular manner up the arm and down the left axilla. The hypertrophy of the hand appears to have been progressive, but sometimes it is more swollen than at others. No similar condition has been observed in any other member of the family. The left hand is larger than the right in the ratio of 9 to 5, as determined by displacement of water. The length of the hand from the fold of the wrist to the tip of the middle finger is

6 in. in the left and 5½ in. in the right, and the breadth is half-an-inch greater in the left. The colour is purplish. The hand looks as though it is ædematous, but does not pit on pressure. The muscles appear to be feebly developed. On X-ray examination the bone appeared normal. There appears to be a lymphangiomatous element in the general hypertrophy. Dr. Pritchard regarded the hypertrophy as due to the increased blood supply dependent on this condition.

The CHAIRMAN agreed that the condition was nævoid. Dr. PARKES WEBER thought it was better to class such cases as angioectatic hypertrophy, because the hypertrophy might involve the venous vessels or the arterial vessels, or the lymphatic vessels, or any combination of the three.

Dr. PRITCHARD also showed (2) Symmetrical helical fistulæ, with branchial fistula in an infant. The case resembled one shown by Mr. Howell Evans at the June meeting, 1904. It showed two symmetrical fistulæ at the anterior aspect of the helix of the ear, about 2 mm. in diameter, and the same in depth. At times they emit a thin secretion. On the left side of the neck, at about the level of the anterior margin of the sterno-mastoid muscle, is a small depression representing in the usual position the vestigial remains of what was once a branchial cleft. In front of the right ear there is a small nodule or pre-auricular tubercle. No other stigmata were shown. Similar helical fistulæ have occurred in several members of the family. The mother, who was present, showed them on both ears, and so did four of her children, deceased. The maternal grandmother and two of her sisters also had symmetrical helical fistulæ.

Mr. A. J. ROOTH and Mr. J. HOWELL EVANS showed a case of

#### CONJOINED TWINS.

Mr. Howell Evans said that Mr. Routh had attended the mother of the twins, but they were born before his arrival. The method of presentation seems to have been normal, the cephalic position for the first child, the legs of the second child then came down, and the birth was accomplished. They belonged to the type of twins which had survived longer than any other-namely, those joined by the buttocks. The radiograph suggested that they were joined with more than fibrous tissue. Though the female genitalia were complete, there was one common anus, the rectum of the second child opening into the rectal ampulla of the first. The mother was one of twins, and there had been other twins in her family. Several members of the father's family had had congenital heart disease. The twins were now about a year old. Conjoined twins of this nature had lived to considerable ages. The only illness suffered had been bronchitis, which began in one child. Medicine was administered to both, but, in spite of this, the second child also had bronchitis. Separation had not been attempted on the ground that the twin which seemed to be weaker appeared to have the greatest amount of alimentary canal.

Dr. G. A. SUTHERLAND showed, for the second time, a case of cirrhosis of the liver in a boy, æt. 11. Ascites had recurred, and 150 oz. of clear fluid had been drained off, since when tapping had been re-peated at intervals. Of late he had been tapped about once in ten days, about 200 oz. of fluid having been drawn off in each case. Fresh spider nævi have developed on the face and extremities. The liver can be felt about half an inch below the ensiform, and The spleen extends about 11 in. below nowhere else. the costal margin. The temperature often rises to 100° at night, but there are no signs of tuberculosis to be obtained. He has had seven doses of fibrolysin without any effect at present. Dr. Sutherland asked whether the surgeons could recommend omentopexy, as the case was one of chronic recurring ascites.

The CHAIRMAN asked what Dr. Sutherland thought vas the cause of the condition, and what was the condition of the heart?

Dr. SUTHERLAND replied that there was no evidence of adherent pericardium. He did not know that syphilis had been excluded, but mercurial treatment as a method of cure had been tried in vain. Still, in advanced cases of syphilitic liver, this would be the

case. The mother died two years ago of alcoholism, but there was no evidence of the patient having been given alcohol.

Dr. G. A. SUTHERLAND showed two cases of CEREBELLAR ATAXY

The first was a child, æt. 4, who had never learned to walk properly. Her gait was ataxic. There is imperfect co-ordination of the hands, the finer movements of the fingers being defective. The mental condition is considered normal, but temper very bad. Sensation is normal. The knee-jerks are very active, the plantar reflex shows a flexor response. There is no nystagmus or fundal change. The second case is a female, set. 21, sister to the above. She has never learned to stand or walk, can sit up, but always sways about and has irregular jerking movements. She has a vacant look, arregular jerking movements. She has a vacant look, and her speech is not very intelligible. There is no nystagmus or fundal change. The muscles are hypotonic. These are the only children of the family. The symptoms suggest imperfect development of the cerebro-cerebellar system, and more especially of the cerebro-cerebellum. There is no history of syphilis.

Mr. Sydney Stephenson showed a case of

OXYCEPHALY in a boy, aged 32 days, who was admitted to hospital with ulceration of the right cornea. The right eyeball protruded from between the eyelids immediately after birth. The labour was easy. The eye bulges forth birth. The labour was easy. The eye bulges forth whenever the baby screams or is bathed. The child weighed 5 lbs., had a red and wrinkled skin, loud "snuffles," and a slight papular rash on the hands and arms and trunk. The skull is typical of oxycephaly, the frontal region rising steeply and overhanging the face. The cranium is deficient as regards total size and capacity. All the bones and sutures appear to be present. The eyeballs, especially the right one, are prominent, though they can still be covered with the eyelids. The orbits are clearly deficient in depth.

The Chairman said that those interested in such

The CHAIRMAN said that those interested in such cases as this might like to know that at the Royal College of Surgeons all the abnormal skulls had been

College of Surgeons all the annormal skulls had been arranged in series by the new Curator, Dr. Keith.

Dr. H. MacCormac showed a case of congenital laryngeal obstruction in a girl, aged 5 months. The infant was brought to hospital on account of a "cough from birth." On examination, there was a faint purring noise to be heard during quiet breathing, which became more evident on forcible respiration. The mother said that the condition had existed since birth, that it seemed to produce no inconvenience, and that it disappeared during sleep. No physical signs of pulmonary disease were found, nor was there any indrawing of the lower part of the thorax.

Dr. PARKES WEBER read a paper on CONGENITAL OBLITERATION OF THE BILE DUCTS WITH

HEPATIC CIRRHOSIS.

The patient, a boy, aged 3 months, was admitted to hospital suffering from malnutrition and jaundice of moderate degree. The mother said the child had been jaundiced from birth. No other member of the family had jaundice. The mother had had no miscarriages. The child's liver was enlarged, but not tender. riages. The child's liver was enlarged, but not tender. The faces were acholic and rather copious. The urine contained bile pigment and one or two granular casts. Blood examination: Hb. 90 per cent., red cells 3,900,000, white cells 9,400. Differential count (made by Dr. J. C. G. Ledingham): Polymorphonuclears 61 per cent., large lymphocytes 26 per cent., eosinophils 3 per cent., small lymphocytes 1 per cent. In a month the child had gained one pound and the jaundice began to diminish. The spleen, however, had increased in size for its lower border could be felt one inch below after two months in hospital the temperature was frequently raised to 101° or 102°. At the age of five months convulsions set in and the child died. Necropsy: The gall-bladder was represented by a fibrous scar, and the common bile duct was hardly pervious. These congenital changes were doubtless partly inflammatory in origin, and, as usual, were un-accompanied by congenital defects elsewhere in the body. The hepatic cirrhosis was found to be chiefly of interacinous distribution, and was doubtless to some extent a result of the Abstruction.

Dr. H. D. Rote and that Dr. Weber's case

aid that Dr. Weber's case

differed from the ordinary run of cases of congenital obliteration of the bile ducts. The distribution of the fibrous tissue was different, and there was a curious condition about the enlarged glands in the portal fissure in that they were matted together and that there was practically a stricture produced in the portal fissure by an inflammatory condition outside the ducts. The question arose as to whether it might be a case in which the obstruction of the ducts was produced outside the ducts. The only point against that was the practical obliteration of the gall-bladder. His own belief was that there was no congenital narrowing of the ducts at first, but that from the beginning it was an inflammatory toxic process. This was contrary to the view upheld by Dr. Thompson and advocated in America.

Dr. G. CARPENTER said the question, in his mind, was whether syphilis had any part in the causation of obliteration of the bile ducts, and he quoted two cases which had been under his own observation in which there was no doubt that syphilis was present. In a third case there was no evidence of syphilis. In this the cystic duct had been obliterated, and the gall-bladder was full of bileless mucus.

Mr. RALPH THOMPSON read a paper upon congenital dislocation of the hip-joint and showed a number of specimens clearly illustrating the points which arose. He put forward the view that the changes associated with pressure or static dislocation of the hip are too frequently regarded as primary and as producing the dislocation, whereas in many cases of congenital dislocation no deformity is noticed until the child begins to walk, and the deformity occurs in well-developed female children in whom the mechanical conditions are more likely to produce dislocation at the time of the adoption of an erect attitude than is the case in males. The changes found are a shallow and triangular acetabulum, a small flattened head of the femur with a short and anteverted neck, deficiency in the iliac segment of the acetabalum and hour-glass constriction of the capsule, a stretched or absent ligamentum teres and some coxa valga shortening of the leg below the knee. These conditions could all be explained by considering the mechanics of the joint in children of two to three years. Mr. Thompson gave full demonstrations of these points.

Thompson gave full demonstrations of these points.

Mr. Hugh Lett said the Section was very much, indebted to Mr. Thompson for his paper, which had evidently been produced with a great amount of care, and entailed much work. The theory he brought forward was interesting and important. All whohad seen cases of congenital dislocation of the hip must have been struck with the remarkable fact that those children did not appear to have anything wrong until they were three or four years of age. No-called or anything of the kind had been noticed: simply that the child had perhaps limped ever since she could walk. He would like to consider the paper more carefully before speaking decidedly about it; but there was much, from an anatomical point it; but there was much, from an anatomical point of view, in what was brought out, particularly in connection with the foctal pelvis, and the relations of various lines of force in male and female. He believed Mr. Thompson's view would be accepted by many authorities, and those who did not accept it would be bound to weigh it with great care before putting it on one side.

The CHAIRMAN said he had been accustomed to point out that when a child had been taken off its walking on one limb, from any cause, not only the thigh but the feet and all the bones of the limb were shortened from the lack of use. He understood from the argument that as the female was less protected than the male from dislocation of the hip, it was unwise to place the female child on her feet so early as the male

> CENTRAL MIDWIVES BOARD. MEETING HELD JUNE 24TH, 1909. Dr. CHAMPNEYS in the Chair. PENAL CASES.

Two women were cited to appear before the Board. One of them was charged with persistent failure, after repeated warnings, to notify the fact of having called

in medical aid. The other, Emma Pitman, who appeared in person and was defended by a solicitor, was a complicated case. The principal charges against her were those of false entries in her register-two cases which appeared there as having been given up "doing well" having died. Dr. Stephenson, Medical Officer for Bridgwater, and Dr. Hartnoll, who had been called into one of these cases, gave evidence. The Bridgwater District Nursing Association, from which Dr. Hartnoll had obtained a nurse to attend the second case, refused to allow the nurse to give evidence, a point which was commented upon by the Chairman as increasing the difficulties of the Board and neglecting a public duty. The scanty evidence which was forthcoming showed the midwife to have failed to realise the serious condition of these two patients. One she had left two days before her death, thinking her to be going on all right. The other she found, four days after confinement, in a condition which she attributed to worry and lack of food and firing, and did not call in medical assistance. A few hours later when the doctor was called in by the nours later when the doctor was called in by the husband, he found her semi-comatose, with a temperature of 103°, and suffering, in his opinion, from septicæmia. She died the following day, and Dr. Hartnoll, signed the certificate of death in accordance with the foregoing symptoms. He did not, however, notify the case within the prescribed time, nor warn the midwife, with the result that she continued to practice without disinfection. The woman was severely censured. and disinfection. The woman was severely censured, and a report of her work was to be asked from the local supervising authority in three, and again in six months.

GENERAL MEETING. At the close of the penal session the usual business of the month was dealt with. Letters had been received from Dr. Thresh, County Medical Officer for Essex, and Mrs. Gifford, Hon. Secretary of the Oldham, Copford and Mark's Tey Nursing Association, as to the refusal of medical practitioners to attend when summoned on the advice of a midwife. The Board replied that no blame could be attached to the midwife if she strictly carried out the rules as to summoning medical assistance. In reply to requests from certain training schools and nursing associations in Devon and Cornwall, it was agreed that the written part of the examination might be held locally, subject to an undertaking being given to observe the terms and conditions fixed by the Board as to the conduct of the

The Board appointed Clifford White, M.D., M.R.C.P., F.R.C.S., on the list of Supernumerary Examiners. The following were approved as teachers:—John Singleton Darling, M.B., Samuel Charles Collingwood Fenwick, M.D., Thomas Thomson Rankin, M.B.

A letter was read from the General Secretary Medical Defence Union as to a certified midwife prescribing for a patient suffering from influenza, and appending the initials C.M.B. to her name.

In reply, it was agreed that the Medical Defence Union be informed that the midwife has undertaken to discontinue the use of the initials C.M.B., and that it does not appear from the evidence before the Board

nt does not appear from the evidence before the Board that the midwife has prescribed. Her name was merely appended to an advertisement for powders.

At the last examination for the certificate of the C.M.B. the number of candidates was 607, considerably exceeding any previous number. Of these, 495 passed, making the percentage of failures 18.5.

The next meeting of the Board will be on July 22nd.

### CORRESPONDENCE.

#### FROM OUR SPECIAL CORRESPONDENTS ABROAD.

#### FRANCE.

Paris, June 27th, 1909.

TROUBLES OF THE MENOPAUSE.

THE hygiene and treatment of the menopause is directed towards possible complications. The change

of life is frequently a troublesome physiological condition, but it is not a malady.

A treatment which has come into vogue these recent years consists in administering by the mouth or sub-cutaneously ovarian extracts of animals. By this-method—organotherapy—an attempt is made to restore to the woman in a sort of artificial way the useful principles lost by the normal cessation of the functions of the ovaries. A certain relief is in reality obtained, as assured by Jacobs, of Brussels, under the following conditions :-

(1) The troubles of the natural critical period disappear or are notably improved by ovarian extract.

(2) The same results are observed in the troubles experienced after surgical operations on the female organs with more or less mutilation.

(3) Anæmia of young girls and that following delivery or operation disappears rapidly by ovarian injection.

(4) Certain cases of grave mental disturbance are

definitely cured by this treatment.

Against nervous trouble, vertigo, sensation of heat, valerian or the bromides are useful:—

Bromide of potassium Bromide of sodium 21 dr. Bromide of ammonium

Syrup of orange, 5 oz.

A teaspoonful morning and evening.

Sensation of heat may be treated by hydrotherapy, cold douches, or, according to the method of Gortschalk, a warm bath each evening of twenty minutes' duration.

For acne of the face, so frequently observed, pills of ichthyol, as advised by Unna (5 grains twice daily), and lotions of the same agent:—

Ichthyol, 1 dr. Spirit, 2 oz.

Sulphuric ether, 2 oz.
Ess. of thyme, 15 drops.
A teaspoonful in a little water as a lotion.

At night the following ointment might be applied:-

Sulphur, dr.
Talc powder, 1 dr. Oxide of zinc, 1 dr. Ess. of bergamotte, 5 drops. Vaseline Lanoline 4 drops,

If hæmorrhoids be present, cold enemas, belladonna, or rhatania ointment and suppositories of hama-

Ext. of hamamelis vir., 2 gr. Cacao butter, 1 dr.

Vicarious hæmorrhage by the mouth, nose or lung is best treated by rest in bed and ergotin. Hydrastis canadensis is an excellent remedy in such cases: fluid extract, 50 to 80 drops a day; tincture, 20 to 30 drops; hydrochlorate of hydrastin, 2 to 4 grains daily.

Frequently urinary troubles are observed, manifested

by frequenty urinary troubles are observed, manifested by frequent desire to micturate. The symptoms are due, not to cystitis, but to neuralgia of the bladder (cystalgia), and are best treated by warm baths and the introduction of an ovule of solidified glycerine into the vagina; by its detergent action on the uterus great relief is obtained. The internal treatment consists in giving 10 grains of bromide of potassium four times a day, and five days before and five days after the menses 10 drops of tincture of hydrastis cana-densis three times a day. At the same time a bottle of Contrexéville water will be drunk each day before

Metrorrhagia of the critical period is frequently very troublesome, both from its duration and repetition. Injections of very hot water three times a day, and quinine by the mouth (5 grains twice a day) are generally sufficient. To prevent a return, hydrastis canadensis (80 drops daily), and if the patient complains of much pain:

Tincture of Indian hemp, 1 dr. Tincture of hydrastis Tincture of piscidia Tincture of viburnum

Twenty drops in water three times a day. Gelatin seems to give good results. A warm solution of 10 per cent. is injected subcutaneously or employed in plugging. Ovarian extract is also useful, and is of current practice (2 gr. three times a day).

CEREBRO-SPINAL MENINGITIS.

The diagnosis of verebro-spinal meningitis is not always easy, and in some cases almost impossible. Where in adults, or in children old enough to understand the questions put to them the essential features and the usual symptoms of the affection pass easily before one's eyes, and where the malady exists in a sort of epidemic form in a locality where already other cases have been observed, the diagnosis is relatively easy, independent of bacteriological examination. But such is far from being always the case. The disease may be of a sporadic nature, while it frequently attacks very young children, incapable of assisting the physician. Again, it frequently develops, suddenly carrying off the victims in a few days or a few hours, without giving time for a well-established diagnosis and consequent treatment. Prof. Heubner, of Berlin, who is regarded as an authority on the subject, declared that it was impossible to distinguish hyperacute cerebro-spinal meningitis from other forms of meningitis. Grawitz says that the differential diagnosis between tuberculous and sporadic cerebro-spinal meningitis is extremely difficult to establish at the beginning, the clinical forms being about the same.

For Bejinski, on the contrary, a doctor with some experience ought to be able to pronounce on the character of the meningitis. In the cerebro-spinal form, either the child falls suddenly into a comatose state and succumbs after three or four days, or perhaps hours, or the disease may be prolonged several days, the patient maintaining consciousness. In cases of tuberculous meningitis, on the contrary, somnolence persists, progresses gradually with the duration of the malady with, perhaps, periods of lucidity, but they are always short and transitory. In this last affection the fever is generally low, between 100° and 102°, rarely over, while in cerebro-spinal meningitis the temperature is high at the outset, only lowering towards

Never is the stiffness in the neck in tuberculous meningitis as pronounced and persistent as in the cerebral form, where it persists to the end.

In cerebro-spinal meningitis the liquid furnished by the lumbar puncture is remarkable for its abundance; it comes out in a jet, is cloudy and presents a purulent deposit. In tuberculous meningitis the liquid is limpid with a very slight deposit.

Be that as it may, the three capital symptoms of cerebro-spinal meningitis are: Stiffness of the neck, vomiting and headache. One or two of these first symptoms, however, may be wanting, while the third may pass unnoticed, as in the case of very young children. A sign of great value, however, in these latter is the tension of the anterior fontanelle from the increased pressure within.

Examination of the rachidian liquid is the only means of removing doubt as to the nature of the malady. The presence of meningococci and lymphocytes in the liquid is sufficient evidence in most cases.

But where the bacteriological examination is not within reach of the medical attendant, diagnosis is frequently possible without the aid of the laboratory if the following elements furnished by the particular case

are taken into consideration:

The age of the patient; it is said that no other form of meningitis is found in infants.

The bulging forward of the anterior fontanelle in children in whom the cranium is not completely

The fact that the patient maintains consciousness almost intact up to an advanced period of the disease.

The remittent and irregular character of the febrile condition.

The progressive character of the wasting up to the point of emaciation.

The ophthalmic phenomena usually accompanying cerebro-spinal meningitis.

AUSTRIA.

PREVENTING INJURY BY RÖNTGEN RAYS. GOTTWALD gave the Gesellschaft der Aerzte an account of his experiments with the Röntgen rays. He

affirmed that the rays acted on the tissue inversely to its intensity and metabolism. On the tissues of dogs he found when they were compressed and their nutrition diminished the action of the rays was very slight. If this experiment be tried on the cutaneous surface under pressure with either the Röntgen rays or radium it will be found hyperæmic, while the control experiment carried out in the same way without pressure will be found inflamed and the vessels hypertrophied. Again, if the rays be applied to the hairy scalp in the usual way the hair will soon fall out, but if pressure be applied during the exhibition of the rays the hair does not fall out. Hence to protect the tissues under these rays it is necessary to use compression.

TUMOUR ON THE ACOUSTIC NERVE.

Schwarz next presented a man who seven years ago commenced to take giddy turns, followed in a short time by deafness, difficulty to swallow and paralysis in the right side of the palate and vocal cords; the mucous membrane of the trachea was hyperæsthesic, and both parally in the area was appreciated.

and both papillæ in the eyes were congested.

Within the last five weeks these symptoms have changed to a more aggravated form of staggering, right facial paresis and absolute deafness. There is, also, right nystagmus, papillitis, anæsthesia of cornea, a lowered sensation of taste and loss of abdominal reflex, while the tendon reflex was increased on the left side.

He diagnosed the case as one of tumour on the acoustic nerve, compressing the facialis, corpus restiforme, the spinal trigeminus root, and the pyramidal path.

He then discussed the best method of operating in this complicated position.

TUMOUR AT THE BASE OF THE BRAIN. Algyogyi showed a female patient, æt. 37, who for the last ten years has suffered from severe frontal head ache and for the last two years from partial loss of vision. The left pupil did not react to light, the cornea was anæsthetic, and both optic nerves were atrophied. The Röntgen rays revealed a saccular, perforated floating tumour at the base of the brain near the sella turcica. He considered it an osseous tumour in some way connected with the destruction of the sella turcica.

PATHOGENESIS OF ARTERIO-SCLEROSIS.

Biedl and Braun have been carrying out a few laboratory experiments on animals with the hope of demonstrating the proximate or immediate cause of arterial sclerosis. On expounding their views to the Gesellschaft der Aerzte they considered the real cause to be mechanical, and to support this recounted their experiments on dogs where the abdominal aorta was compressed, which produced sclerosis in the thoracic portion of the aorta. This compression was performed on perfectly healthy dogs, leaving no doubt concerning the results. These compressions were made on the aorta immediately above the renal arteries, and only for two minutes daily by pressing the artery against the spinal column. In other cases their experiments were with dry food-stuffs, which certainly produce changes in the structure of the aortic vessels, but not the sclerosis. It cannot be denied that dry food, such as meals, biscuits, etc., is also an active factor in the production of sclerosis, particularly in the small arteries, but the large vessels are not exempted. A peculiar experience was given that absolute hunger, deprivation of food and water was also fruitful in producing sclerosis or changes resembling this pathological condition.

RESPIRATORY GYMNASTICS.

Hofbauer next presented three cases of pulmonary emphysema which he had successfully treated by Freund's method of respiratory gymnastics, which he has practised for several years now. His object was has practised for several years now. His object was to obtain mobility of the costal parietes, and to increase this movement he divided the costal cartilages. All the patients met with the same happy result. Before treatment all were unable to walk or lie down in bed, and were quite cyanotic. Now they are able to walk upstairs with ease and lie down in bed, without any discomfort. The general condition is improved, cyanosis gone, and the heart relieved.

The Royhean method seems to be quite ineffectual in

The Boyhean method seems to be quite ineffectual in restoring the circulation. Dietetic treatment when

exercising the respiratory muscles must not be neglected. The expiratory exercise is important after dividing the cartilages, as it permits of complete contraction of the abdominal muscles and thus greater elevation of the diaphragm.

#### HUNGARY.

Budapest, June 26th 1909.

AT the recent meeting of the Interhospital Association, Dr. Fóth read a paper on

THE ELECTRIC TREATMENT OF UTERINE MYOMATA. He said that in spite of the shortcomings of this method, it has been further studied by many physicians, amongst them by himself. He has even perfected a method which apparently gives satisfactory results. His plan is to produce firm uterine contractions by strong faradisation, with the idea of causing the blood vessels to contract, and thus check the hæmorrhage, while at the same time the nutrition of the thage, while at the same time the nutrition of the tumour is interfered with, and it diminishes in size by a process of absorption. He passes one electrode through the cervix into the uterus, while the other is applied to the abdomen. If possible, the treatment is continued daily from twenty to thirty minutes, and the current is used as strong as the patient can stand Both the strength of the current and the frequency of application must be carefully regulated at the begin-ning of treatment in order not to overtax the patient. The author has never observed any bad effects from the treatment, and has found that the metrorrhagia is entirely controlled and the tumours are greatly reduced in size.

#### INTESTINAL TUBERCULOSIS IN CHILDREN.

In the Orvosok Lapja a type of tuberculosis occurring among the children of coal miners in Hungary is described by Dr. Richter. It affects principally the intestinal lymph glands, and though rarely fatal, may constitute a grave illness. The children fatal, may constitute a grave illness. The children become emaciated, pale, suffer from abdominal pain and tenderness around the umbilicus, headache, insomnia, and slight rise of temperature in the evening. The cervical and sub-maxillary glands are frequently swollen. The disease may progress very rapidly for a time, and then take on a chronic type, which is more time, and then take on a chronic type, which is more apt to be prolonged in the older children. After the subjective symptoms disappear, anæmia, and general weakness persist for a considerable period. The author ascribes the disease to the fact that the local milk supply is of very poor quality and the hygienic conditions are also bad. In view of the fact that Behring states that tuberculosis infection in childhood protects against reinfection later in life, it is interestprotects against reinfection later in life, it is interesting to note that tuberculosis is very rare among the adult inhabitants of the district.

#### DIAGNOSTIC VALUE OF BLOOD EXAMINATION IN SURGERY.

Juffier is reported in the Orvosi Revue as follows:-"Cryptoscopy of the blood is now a method of value in the diagnosis of renal disease. Whenever the increase of molecular concentration shows a persistent insufficiency of the kidneys, nephrectomy ought not to be performed. Unfortunately this method does not give constant results in renal disease; the increase of molecular concentration does not always indicate a bilateral lesion, and even in insufficiency of uræmia the point of molecular concentration may be normal or sub-normal. The hæmoglobin index is valuable. Mikulicz does not operate if it is below 38 per cent. except by means of local anæsthesia. Bloodgood and Cabot do not believe in general anæsthesia if the hæmoglobin is below 70 per cent. The study of the red corpuscles is of less importance to surgery. The iodophil reaction of the leucocytes in suppuration is interesting. Locke, in 800 cases, claimed great value to the test in demonstrating the existence of a focus of suppuration. It has been obtained, however, in gonorrhœal rheumatism.

The presence of leucocytosis is valuable in pointing to hidden purulent inflammation, especially in appendicitis, and a disproportion between the temperature and the leucocytosis is even more important. In rupture of the viscera following a contusion of the abdomen, Cazin has demonstrated a rapid increase

of leucocytes. In intestinal perforation in typhoid fever the hypoleucocytosis suddenly changes to hyperleucocytosis. In carcinoma a gradual diminution of the red corpuscles, an equal decrease of hæmoglobin, and a polynuclear leucocytosis is suggestive of malignancy. In gynæcology it may or may not assist the diagnosis.

### FROM OUR SPECIAL CORRESPONDENTS AT HOME.

#### SCOTLAND.

CHAIR OF SURGERY, UNIVERSITY OF EDINBURGH.-The Curators have invited applications for this Chair, and among the names mentioned in connection with the vacancy are those of Mr. Alexis Thomson, Mr. David Wallace, Mr. W. B. Hodsden, Mr. C. W. Mr. David Wallace, Mr. W. B. Hodsden, Mr. C. W. Cathcart, and Mr. Alx. Miles, all of Edinburgh. Applications, with relatus testimonials, must be lodged with Mr. N. H. Johnston, Secretary to the Curators, 4 Albyn Place, Edinburgh, on or before July 15th. Edinburgh

EDINBURGH INFIRMARY RESIDENTS' CLUB.—On account of the death of Professor Cunningham the

account of the death of Professor Cunningham the Annual Dinner of this club, which was to have taken place this month, has been indefinitely postponed.

MEDICAL INSPECTION OF SCHOOL CHILDREN.—The Edinburgh School Board has agreed to appoint two assistants—one male and one female—to their medical officer, at salaries of £250 and £200 respectively, and two nurses at salaries of £60, to carry on the work of inspection. In Dr. Hally Meikle's report for 1007-8 the following recommendations are report for 1907-8 the following recommendations are made:—(1) More stringent dealing with dirty and verminous children. (2) Following up cases and home visits by nurses to see that orders are obeyed. (3) Schools for special skin diseases, such as favus and ringworm. (4) Relaxation of quarantine regula-tions for minor infectious diseases. (5) Infectious diseases history of pupils to be recorded on their entrance forms. There certainly seems much reason to relax the quarantine regulations, not only in the Board schools, but also in the public schools, in some respects. Edinburgh has this winter been visited by an unusually widely-spread epidemic of mumps, and the result has been that from the need for adhering to the ordinary quarantine regulations the education of the rising generation has been sadly hindered. Classes have been down to a half of the normal number -the average absence has been something like 35 per cent., and it has been no uncommon thing to have had whole families kept from school for several months at a time by reason of successive cases of mumps among them. The question of dealing with infectious diseases in day schools is a difficult one, but it does seem as though, in the case of a disease like mumps, with long incubation and quarantine-periods, and a long period of infectiveness, some-middle path might be found whereby, without unduly exposing the healthy, the extreme rigour of quaranting and withdrawal from school for long periods could be mitigated.

#### LETTERS TO THE EDITOR.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

SELF-MEDICATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—The evils of self-medication are now seen on Six,—The evils of self-medication are now seen on every hand, and encouragement given by all daily papers, from the *Times* downwards, advertising remedies for all "the ills that flesh is heir to" (thus inincreasing enormously their gains), while the medical practitioner is placed on the same level as the retail chemist. His knowledge, for which he has had to pay well, both by money and risk, goes for nothing in the public estimation, and he is expected to keep the concertable appearance and pay all rates and up a respectable appearance and pay all rates and taxes, and contribute to charity (so-called).

One curse of the nation is self-medication, We find this is literally true, While some in high station prefer operation, And have to pay well for it, too

The chemist advises, sells pills of all sizes,
And capsules and bottles galore,
When folks "can't afford that," then they change coat and hat. And apply at some hospital door.

Free advice they obtain, and they'll try it again, For seldom inquiry is made, And they chuckle and grin at the physic "thrown in," For which they with ease could have paid.

The domestic well-dressed, who struts out in her best, And squanders her wage on a hat, When wanting advice will think over it twice Before she'll pay money for that.

The payment denied to poor doctors outside Finds its way to the public-house till, Or a game at football, or a low music-hall, Legatees—think of this in your will.

I am, Sir, yours truly,

THE EMOLUMENTS OF CHRISTIAN SCIENCE, To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,-May I be permitted to ask Mr. Dixon a purely

business question, apparently involving neither theology, metaphysics, or philosophy?

If Mr. Dixon and his cult claim, as they appear to do, for the work, "Science and Health, with Key to the Scripture," such unprecedented merit, as they never cease to exhort one to consult this book, why do they restrict its circulation by means of a prohibitive price as concerns the great majority of the

general public?

Further, Mr. Dixon will note that the late Dean Farrar's "Life of Christ" and "Renan's Life of Jesus," works of unquestionable great literary merit (both of which I happen to possess) are procurable for the nominal sum of 6d., the "Key to the Scriptures" costing, I believe, twenty times the amount. The veritable Scriptures themselves, at least as regards the "Synoptic Gospels," as they are called, I think, can be had for the nominal price of id. or 2d. If Christian Science is not a moneymaking concern, why do the cult confine their propaganda and literature to the wealthy?

I am, Sir, yours truly, CLEMENT H. SERS.

Brighton, June 24th, 1909.

CHRISTIAN SCIENCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—The characteristic letter from Mr. Dixon in your current issue needs no more comment than what you append to it. No doubt Mr. Dixon believes all he says, but his belief can be based only on mingled delusion and ignorance. The real character of Christian Science has been fully exposed more than once in your pages, and in that exposure I have several times taken part. To examine it again for a scientific audience would seem very much like breaking a fly for a second time on a wheel; the mere statement of its claims shows it to be simply a farrago of blasphemous nonsense. However, a first-rate writer—the distinguished author of "Confessio writer—the distinguished author of "Confessio Medici"—has taken the trouble seriously to examine in detail the whole question; and to those of your readers who have not seen the book, and wish fully to inform themselves on the subject, I would commend the volume to which I refer. It is entitled "The Faith and Works of Christian Science," and, like all its author's writings, besides being a masterly exposition, it affords a high intellectual treat. With regard to that class of Christian Science practitioner whose methods are the expression of blasphemous imposture, the author sums up their performances in the following passage:—
"They bully dying women, and let babies die in

pain; let cases of paralysis tumble about and hurt themselves; rob the epileptic of their bromide, the syphilitic of their iodide, the angina cases of their amyl nitrite, the heart cases of their digitalis; let appendicitis go on to septic peritonitis, gastric ulcer to perforation of the stomach, nephritis to uræmic convulsions, and strangulated hernia to the miserere mei of gangrene; watch day after day while a man or a woman slowly bleeds to death; compel them who should be kept still to take exercise; and with-hold from all cases of cancer all hope of cure. To these works of the devil they bring their one giftwilful and complete ignorance."

It is amazing that at the opening of the twentieth century, when enlightenment is the boast of our advanced civilisation, there should exist vast masses of the British people as credulous as were the populace in the days of witchcraft. They believe in Christian Science; they spend in these islands annually at least four millions sterling on fraudulent continuously and borne constants. nostrums and bogus apparatus; they flock in crowds to any blatant quack pretender who promises to cure their diseases by methods which could only be explained in every instance by the working of a stupendous miracle.

I am, Sir, yours truly,
A SURREY DOCTOR.

June 25th, 1909.

PREVENTION OF DENTAL CARIES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR. SIR,—It is important that the true cause of rickets should be understood. The writer of the letter signed "M.R.C.S., L.D.S." in this week's MEDICAL PRESS AND CIRCULAR gives to rickets "a first place" among the "constitutional diseases giving rise to the causes of caries," and states that "the main cause of rickets) is improper feeding." The main cause of rickets is not improper feeding. The analysis of 2000 rickets is not improper feeding. The analysis of 3,000 cases of rickets to which reference has been made lately in the British Medical Journal led me to the conclusion that the main cause is some defect in the pulmonary conditions of infants and young children, and that we must look to imperfect blood aeration as the chief cause of rickets.

During the last few years this view, which was published some years ago, has been confirmed by further

observations.

I am, Sir, yours truly, ROBERT LEE.

Pwllheli, June 25th, 1909.

THE "NORMYL" TREATMENT.

To the Editor of The Medical Press and Circular Sir,—I have before me a cutting from your journal of June 23rd commenting upon the Rev. Hugh B. Chapman's recent article on the Normyl Treatment, which appeared in the Daily Mail. You appear to ignore entirely the fact that during the last four years the Normyl Treatment Association has dealt with over 5,000 victims of the drink and drug habits, and that the failures known to the Association number less than 8 per cent. of this total, and we have in our possession 8 per cent. of this total, and we have in our possession hundreds of letters of gratitude and appreciation from patients and friends of patients who have been cured by this treatment. There is a certain eloquence of facts, even in the absence of any medical sanction, and I commend this testimony of the value of the Normyl Treatment to your consideration. I would also add that I know of no human remedy which can possibly prevent a person from drinking who deliberately prefers to do so, but the Normyl Treatment to some extent acts as a substitute for the alcohol, from which we instruct the patient to abstain, and after an almost immediate relief of the craving, so restores the energy and renews the will-power that no patient should thereafter be liable to lapse through sudden temptation. The medicine is gradually increased in strength day by day until a maximum is reached. Afterwards it is as steadily graded down, so that the patient does not come to rely too much upon its tonic effect, and so substitute one habit for another. On this particular aspect of the question a well-known medical man has written as follows:-

"A prescription containing a drug which is very active as (f) a local stiumulant to get rid of alcohol and enable food to be taken, and (2) a general stimulant to produce a feeling of bien three and tide over the dangerous time until the normal vigour and will-power return, must obviously prove phenomenally successful, and such a prescription is presented to the public in the Normyl Treatment."

It is also an interesting fact in the history of our Association that, although when we commenced our work there were fewer than half-a-dozen doctors who would recommend our treatment, to-day, after four years' work, we have over 150 doctors who have prescribed the treatment for their patients, and it is significant that in nearly every case where a medical man has once recommended the Treatment in his practice, he continues to recommend it. I feel sure that this record ought not to be despised, and I do not think that any work carried on in this manner, and with such admirable results behind it, deserves to be hindered.

I am, Sir, yours truly,
WILLIAM PORTEOUS.

June 25th, 1909.
[We publish the above letter because we do not like to be thought to treat unfairly any of those we feel it our duty to criticise. Readers, however, will notice that it meets none of the points we raised, and they will consequently form their own conclusions.—Ed. M. P. AND C.]

### **OBITUARY.**

PROFESSOR D. J. CUNNINGHAM, M.D., F.R.S. THE University of Edinburgh has sustained an almost irreparable loss in the death of Professor Cunningham, which took place on June 23rd. Dr. Cunningham had been in bad health since last autumn, and in December went to Egypt in the hope of regaining strength. As time went on, however, it became all too evident that his symptoms were due to serious organic disease, and since his return to Edinburgh in the spring he has been confined to bed, and gradually losing strength. He suddenly took a turn gradually losing strength. He suddenly took a turn for the worse, and died on Wednesday last. Professor Cunningham—"Dan Cunningham," as he was called by everyone—was the youngest son of the Rev. Principal Cunningham, of St. Andrews. He was born in Crieff, and began the study of medicine at Edinburgh when he was seventeen. In 1874 he graduated M.B., C.M., with first-class honours, and two years later was awarded a gold medal for his thesis on "The Anatomy of the Cetaceæ." From 1876 to 1884 he filled the post of Senior Demonstrator of Anatomy to Sir William Turner, and at the same time Lecturer at the Dick Veterinary College. In March, 1882, he was called to Dublin to fill the Chair of Anatomy at the Royal College of Surgeons, whence, in October, 1883, he was transferred to a similar post at Trinity College, Dublin. On the appointment of Sir William Turner to the Principalship of the University, the Curators took the exceptional course of inviting Cunningham, as the man preeminently fitted to occupy the Chair, to come to Edinburgh as Professor of Anatomy, and since he accepted the post in 1903 he has filled the office with distinction, and has been a great power for good in the councils of the University. Professor Cunningham's eminence in the scientific world is well known. His "Dissector's Guide" and the "Text-book of Anatomy," which he edited, are both recognised as standard authorities on his own subject. Among his best-known memoirs are his report on the Marsupialia, brought home by H.M.S. Challenger, his papers "On the Lumbar Curve in Man and the Apes," "On "On the Lumbar Curve in Man and the Apes," On the Surface Anatomy of the Cerebral Hemispheres," "On Acromegalv and Giantism," "On Right Handedness and Left Handedness," and on the "Anatomy of the Stomach." In all of these his ability as an investigator and his originality as a thinker were well displayed.

Dr. Cunningham acted at one time or another as Examiner in nearly all the Universities and on the Indian Medical Service. He was an Hon. M.D. of

Dublin, D.C.L. Oxon, and LL.D. St. Andrews and Glasgow. He was for eight years Secretary of the Zoological Society of Ireland, and was also Secretary, and Vice-President, of the Royal Society of Dublin, President of the Anatomical Society, of the Anthropological Section of the British Association in 1901, and held office in many other scientific bodies. His ability as a man of affairs, his organising and administrative powers, and his tact and courtesy were among the qualities which led to his services being requisitioned on Boards of Inquiry and Commissions. He served on the Vice-Regal Commission on the Inland Fisheries of Ireland (1900), on the Royal Commission to Inquire into the Care of the Sick and Wounded during the South African War (1901), and on a War Office Committee appointed to report on the Physical Standards Required for Candidates for Commissions and for Recruits. In these various spheres his opinion is for Recruits. In these various spheres his opinion is admitted to have carried great weight, and when Mr. Haldane introduced the Territorial Army Scheme, Cunningham took a leading part in arranging for the medical administration in Scotland. We have not spoken of his personal character, but everyone who ever met or saw Dr. Cunningham must have been extract by the unrightness, simplicity, and kindliness of struck by the uprightness, simplicity, and kindliness of the man. He was one of those happy mortals who attracted liking on the first acquaintance, which, as time went on, developed into affection and esteem. No man was more beloved and respected by his students; during all the years he spent in Edinburgh no one ever had occasion to utter a single disparaging word concerning Dr. Cunningham, and no member of the Senatus was more beloved both inside and outside the University. When any question arose as to medical teaching his was the first counsel sought; he was accessible to all, from the youngest undergraduate upwards, and was always courteous, sympathetic, and wise in advice.

Dr. Cunningham was in his sixty-first year when he died; he is survived by a widow and grown-up family, one of whom is a member of his father's profession.

#### HENRY HUGH BAKER, M.B.

News has been received from the Sleeping Sickness Camp, near Kisii, British East Africa, of the death of Mr. Henry Hugh Baker from malaria, at the age of 31. Mr. Baker was educated at University College, Oxford. He obtained the M.A., M.B., and B.Ch. degrees of the University in the year 1905, and pursued his medical studies at St. Mary's Hospital, London. He was later appointed Government Medical Officer at Nairobi, British East Africa, and had previously acted in the same capacity at Kharga Oasis, West Egypt. Mr. Baker was a member of the British Medical Association and a Fellow of the Society of Tropical Medicine.

## EDMUND MARSHMAN RUSSEL RENDLE, M.R.C.S., L.S.A.

WE regret to announce the death of Dr. Edmund Marshman Russel Rendle, who passed away at his residence, Ivybridge, on June 21rd. For a considerable time the deceased gentleman, who was in his seventy-seventh year, had been in declining health. Born at Plymouth, Dr. Rendle was the son of the late Dr. Edmund Rendle. He inherited his father's love for the medical profession, was accordingly educated at Glenalomand, and passed into King's College Hospital, qualifying at the age of 21. Returning to his native town, he practised for a while in conjunction with his father. Possessing more than average skill, combined with the charm of his personality, Dr. E. M. Russel Rendle was not long in building up an extensive practice, which he continued to conduct for something like 40 years. From 1866 to 1803 he held the position of surgeon to the Royal Eye Infirmary. Among other offices held by him was that of surgeon to the old South Devon Militia, and he was embodied with them during the Crimean War. Dr. Rendle was present at the Whitsands when the awful disaster occurred which bereft him of three near and dear members of his family, and led to the rection of the monument which is a silent witness to the treacherous character of the quicksands below.

HENRY GORST, M.R.C.S., L.R.C.P.
WE regret to record the death of Dr. Henry Gorst, of Huyton. In the districts of Huyton, Prescot, and Knowsley especially the intimation of his death, which took place after a lingering illness was received with unfairned regret. unfeigned regret. A son of the late Dr. Richard Gorst, who was one of the most notable medical practitioners around Liverpool, he entered upon his father's profession, becoming qualified in the year 1877. He worked at the Liverpool Royal Infirmary and St. Thomas's Hospital, London. He has held appointments as House-Surgeon of the Royal Infirmary and the Liverpool Lying-in Hospital, and was also a Visiting Surgeon to the Liverpool North Dispensary, while in the course of a busy life devoted to his profession he made valued contributions to medical journals. Dr. Henry Gorst joined his father in practice at Huyton in 1880. His remarkable devotion to his work—he would scarcely ever tear himself away from an exceedingly busy practice—really undermined his constitution. Three or four years ago he had appendicitis, and latterly suffered from an internal trouble. The death of such an amiable, clever, and conscientious practi-tioner as Dr. Henry Gorst will be deeply mourned by a very wide circle of friends, among whom the poor and needy assuredly must be counted.

### ROBERT WILSON, M.D.ED.

AFTER a short illness we regret to anounce the death of Robert Wilson, of Alloa. Dr. Wilson, who was a native of Limekilns, studied medicine at Edinburgh University, and graduated M.D. in 1858. After practical of the control of the tising for a year in Alva, he came to Alloa in 1859, tising for a year in Alva, he came to Alloa in 1859, and only a few months ago celebrated his jubilee as a local medical practitioner. In 1877 Dr. Wilson was appointed by the old Parochial Board as Medical Officer for the burgh, and he held that appointment up till two months ago, when he retired. He also held the appointments of Medical Officer under the Factory Act and Medical Referee under the Workmen's Compensation Act for the county of Clackmannan.

DR. NATHANIEL HOBART. We very much regret to record the death of Dr. N. J. Hobart, of Cork, who was for a great number of years one of the leading medical men of that city. Dr. Hobart was over 90 years of age, took the M.R.C.S. London in 1846, and the M.D. of Glasgow University in 1847. Amongst the many posts which he held were those of Senior Surgeon to the North Infirmary, Cork, and Consulting Surgeon to the Incurable Hospital, and and Consulting Surgeon to the Incurable Hospital, and
the Hospital for Women and Children. He also served
as President of the Cork Branch of the British Medical
Association and of the Irish Medical Association.

Dr. Hobart enjoyed a large consulting practice
which extended all over County Cork, and although he
had ceased practice for many years he will be remem-

bered with affection and esteem by many of his former patients and friends. His son, Dr. N. Henry Hobart, has succeeded to his practice.

## MILITARY & NAVAL MEDICAL NOTES.

NON-COMMISSIONED officers and men of the R.A.M.C. are to be trained in semaphore signalling with the view of field units of that corps being able to communicate with each other when on active service.

THE Army Council has approved arrangements for the training at Military hospitals of the matrons on the rolls of Territorial General Hospitals. Each of the latter is allowed two matrons, all liable to be called up for training for seven years in alternate called up for training for seven years in alternate years. The hospitals appointed for the training are the R.V. Hospital, Netley; Q.A. Military Hospital, Millbank; Cambridge and Connaught Hospitals, Aldershot; Military Hospitals at Devonport, Woolwich, Cosham, and Colchester. It is proposed that the training time shall be from June till October in each year and the Captal Officers Commanding in each year, and the General Officers Commanding-in-Chief have been directed to send to the War Office as

early as possible the names of matrons who can give attendance for training in the present season.

THE Burma Pasteur Institute is to be situated on an over 3,600 feet above the sea. The main building of the Institute and the Bacteriological Laboratory will be combined in a double-storeyed building. The Vaccine, Pathological, and Parasitological Sections will be in a single-storeyed building. The probable cost will be five lakhs and 78,229 rupees.

THE Gazette of India publishes reconstructed regulations regarding the grant of study leave to officers of the Indian Medical Service. These are as follows:—Study leave may be taken at any time, but will not be granted more than twice in the course of an officer's service. This restriction does not, however, apply to an officer who has part of his furlough converted into study leave under rule 8. Officers on furlough, or other leave, who wish to have part of it converted into study leave, should address the Under-Secretary of State, India Office, and should attach a statement showing how they propose to spend the study leave. Similarly, officers on furlough or other leave who desire to have it extended for the purpose of study should address the Under-Secretary of State, but in addition to the statement of the proposed study, they must support their applications with documentary evidence of their having obtained the approval of the authorities concerned in India to their applying for an extension of leave.

On Tuesday (yesterday), Sir Alfred H. Keogh. K.C.B. Director-General Army Medical Service, gave an address on "The Special Reserve of Officers, Royal Army Medical Corps," in the Medical School, Trinity College, Dublin.

### SPECIAL ARTICLES.

#### HOUSE DISINFECTION IN TUBERCULOSIS.

An editorial note in a recent issue of a medical contemporary emphasises the importance of thorough disinfection of a house recently occupied by a tubercular patient before it is occupied by a new tenant. In the note in question reference is made to an experience related by Dr. F. Lansing Stebbins, of Geneva. U.S.A. Some ten years ago, Dr. Stebbins had a patient who died of tuberculosis. After his death a new tenant moved into the house which he had occu-pied, and a few years later his wife was found to be in the early stage of the disease, a fate which, within the last few months, has overtaken the tenant himself.

Cases such as this have, of course, been well-known for a long time to members of the medical profession. To mention a classic instance, Brouardel relates how 23 clerks in the same employ succumbed to the disease within eleven years of its first appearance in their office. That a phthisical patient must to a greater or a lesser extent infect the rooms which he or she occupies is now generally regarded as axiomatic, and the disinfection of such rooms usually follows as a matter of course.

The Scotch Local Government Board, in its circulars on administrative control of phthisis, urges upon local authorities the need for the disinfection not only of the residences and places of occupation of phthisical sufferers, but also of all places of miscellaneous public resort. Desirable as is this latter measure, it has not yet become a common practice. As has been said, however, the disinfection of the apartments of consumptives is generally carried out. though whether this application is of sufficient frequency, and whether the method of disinfection is always the most efficient, is open to some amount of doubt. In medicine, as in other things, tradition dies hard, and there still exists a general belief in the efficiency of the time-honoured method of fumigation Sulphurous fumigation, especially, is commonly regarded as a suitable method of disinfecting a tuberculous room. Apart from the fact that disinfection

by this method gives the maximum of trouble to those who carry it out, and even offers a certain amount of danger to the occupants of the house in which it is employed, it has been clearly demonstrated that, even with the most stringent fulfilment of all the conditions essential to its successful working, sulphurous disinfection, while undoubtedly efficient against certain organisms, possesses no reliable germicidal action upon the tubercle bacillus. This being so, it is unsatisfactory to find this method so frequently advo-cated in tubercle-infected houses by those who should know better. On grounds alike of convenience, economy, and efficiency, the use of an approved liquid germicide is much to be preferred to fumigation in case of tubercular and some other infections. The main objection to disinfection by this method is the uncertainty of action of certain liquid germicides, and, so long as the unrestricted sale is permitted of so-called disinfectants" which possess little or no germicidal efficiency, that danger must always exist. But it must be remembered that with the employment of modern methods it is possible to determine with exactitude the action of any disinfectant on any particular organism, and accordingly, where disinfection is carried out under the direction of a medical man, there should be no difficulty in ensuring the use of a germicide capable of destroying the tubercle bacillus. As an auxiliary in the battle against tuberculosis, it would be difficult to over-estimate the value of efficient disinfection. Where it is not efficient, howefficient disinfection. Where it is not efficient, how-ever, it is liable to do more harm than good, for it not only means waste of labour and of money, but, by inducing a false sense of security, brings the process into disrepute.

## MEDICAL NEWS IN BRIEF.

Libel on a Doctor.

BEFORE the Recorder, at the Central Criminal Court, on June 23rd, Charles Foxlee, aged 43, leather-dresser, who was convicted at this court in March, 1906, of libelling Dr. Waddell, a retired medical practitioner, now residing in Cornwall, and was bound over to come up for judgment if called upon, surrendered to receive sentence, he having, it was alleged, committed a breach of his recognisance by repeating the libels. Mr. Leycester, counsel for the prosecution, said upon his conviction Foxlee withdrew all the charges against Dr. Waddell and apologised, but he had since broken his promise to obstain from repeating the libels by sending, not only to the prosecutor, but also to his legal advisors, documents repeating the charges and threatening to have the matter printed. Defendant, addressing the Court, alleged that he had been greatly wronged. Eventually he promised not to repeat the libels, and upon this the Recorder allowed the defendant to be released on entering into a fresh recognisance and finding sureties for his future good behaviour. behaviour.

The City of Glasgow and Lord Lister.

The new surgical block of the Glasgow Royal Infirmary was opened on the 23rd inst. by the Lord Provost. A medallion portrait of Lord Lister was on that occasion presented to the managers by past and present members of the staff. An inscription on the framework states that Lord Lister was one of the surgeons of the Royal Infirmary from 1861 till 1869, and that he then organised the antiseptic system of treatment. Mr. Rickman Godlee, Professor of Clinical Surgery to the University College Medical School, a nephew of Lord Lister, gave a short address on Lord Lister and his connection with the Glasgow Royal Infirmary. He paid tribute to Lord Lister's independence in research, his intense patience and earnestness, and his vast achievement.

Hospital Deputation to Mr. Lloyd George.

A MEMORIAL signed by the following gentlemen has been presented to Mr. Lloyd George asking that certain taxes may be remitted in the case of hospitals:—J. Wolfe-Barry, K.C.B. (Westminster), H. Cosmo Bonsor (Guy's), E. H. Bousfield (London Orphan Asylum), Savile Crossley, Bart. (King Edward's Hospital Fund), Alfred de Rothschild (Queen Charlotte's Lying-in Hospital), Hertford (Midland Counties Asylum), Sydney Holland (London and Poplar Hospitals), Portland (Royal Agricultural Benevolent Institution), John Dickens Powder Bart (Greet Northern), Steelback Dickson-Poynder, Bart. (Great Northern), Stradbroke (Eastern Counties Asylum), G. Wyatt Truscott (Lord Mayor).

Mayor).

The institutions represented in the memorial in addition to the above are:—King's College Hospital, General Hospital, Bristol; Royal Infirmary, Liverpool; Royal Blind Pension Society, Royal National Hospital for Consumption, Ventnor; Brompton Hospital, Hospital for Sick Children, Royal Free Hospital, Queen's Hospital for Children, Soldiers' and Sailors' Families Association, Foundling Hospital, Royal Naval Benevolent Society, British Home and Hospital for Incurables, St. Mary's Hospital, Cancer Hospital, Northern Counties Hospital for Incurables, Earlswood Asylum, Victoria Hospital for Children, University College Hospital, General Hospital, Birmingham; General Infirmary, Leeds; Charing Cross Hospital, Middlesex Hospital, Royal Infirmary, Manchester; Meath Hospital, St. Luke's Hospital for Lunatics, Great Northern Central Hospital, Royal Society for Prevention of Cruelty to Animals, Royal London Ophthalmic Hospital, Royal Victoria Hospital, Belfast; St. Thomas's Hospital, Surgical Aid Society, Dr. Barnardo's Homes, Seamen's Hospital Society. Society.

#### The Tuberculesis Act (ireland).

The Dublin Gasette of last week contains Orders under the Tuberculosis Prevention (Ireland) Act, 1908, for (1) prescribing the forms and stages of tuberculosis, to which and the circumstances in which Section I. of the Act shall apply, and (2) making regulations for carrying into effect the provisions of Section I. of the Act, in urban and rural districts to which Part I. of the Act extends.

The first Order declares that Section I. of the Act shall apply to the form of tuberculosis, known as tuberculosis of the lung, "at any stage at which the sputum discharged by the person suffering is in the opinion of the medical practitioner attending on such person liable to communicate the disease to other persons," provided that the section shall only apply in the following circumstances, that is to say, where the person suffering-

(1) Habitually sleeps or works in the same room as any other person or persons not so suffering; or (2) Is employed or engaged in handling, preparing or distributing milk, meat, or any other article of human food intended for sale to the public.

The second order prescribes the rules to be followed by medical practitioners and sanitary authorities in the issuing, registration, and cancelling of the certificates. Both orders come into force on the 1st prox.

Society of Apothecaries of London.

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THE following candidates have passed the Pre-THE following candidates have passed the Preliminary Examination, June, 1909, as undernoted:—
W. J. A. Laird (with Honours), R. A. Austin, A. J.
W. L. Birchall, I. C. J. Blake, J. Campbell, W. P.
Coney, C. P. F. J. Coyne, G. Dunne, I. J. Eppel, W.
A. N. Fox, F. P. Freeman, T. J. Glynn, M. P. Hatch,
G. Healy, P. E. Kelly, A. Merrin, W. G. D. McCall,
J. B. Minford, N. Mulliner, and J. M. Plunkett.

THERE were 75 cases of cholera reported in St. Petersburg on the 22nd inst., and 76 on the 23rd. The total number of patients in hospital is upwards of 368.

## **NOTICES TO** CORRESPONDENTS. &c.

CORRESPONDENTS requiring a reply in this column are par-ticularly requested to make use of a Distinctive Signature or Initial, and to avoid the practice of signing themselves "Ecader," "Subscriber," "Old Subscriber," etc. Much con-fusion will be spared by attention to this rule.

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Mrs. H. C. N.—The movement for the "own air school".

should be addressed to the Publisher.

Mrs. H. C. N.—The movement for the "open air school" originated in Germany. There is now a strong and active Association in London, and we shall be pleased to forward to the Secretary any communication you may wish to send.

FALKERIX.—The Liverpool birth-rate has fallen from 37.1 in 1884 to 31.7 in 1908. At the same time, the infantile mortality rate for the latter year is the lowest on record in the history of the city. We hope to deal with the matter at an early date.

the city. We hope to deal with the matter at an early date.

FUEL TO FIRE.

OUR attention has been draw: to a letter in the Jewish Chronicle of June 25th, from a correspondent who signs himself "LAC." The writer is evidently gifted with an acute and a logical mind, for he asks why the Jewish Board of Guardians supply tuberculous patients with milk for which there is no guarantee that it is not infected with tubercle bacilli. Judging from the investigations of Professor Klein, 12.5 per cent, of 32 samples taken at railway stations produced tuberculosis when injected into guinea-pigs. We trust "LAC" will induce the Guardians either to pasteurise their eleemosynary milk, or to insist upon guarantees of purity. But "LAC" has, after all, simply set forth the facts of a grim tragedy that is being played daily at the expense of all classes of society. Let us hope the Hebraic directness of purpose will lighten that particular area of so absurd a practice as feeding tubercular patients with tuberculous milk.

VIATOR.—Violet leaves have been lauded in the properties of the second of the second contractions and the second contractions are a second contractions as feeding tubercular patients with

tuberculous milk.

Viator.—Violet leaves have been lauded in the treatment of cancer, and their therapeutic claims have been weighed in the scientific balance and found wanting. There are many other plans of treatment, but none has yet seriously threatened the efficacy of the knife when used at an early stage.

Mr. J. S. Sargerr.—You are not quite correct in your figures regarding the two cities. The latest figures given in the Registrar-General's official report are:—Liverpool, 760,357; Clasgow, 872,021; so that the claim of the latter as the second largest city in the United Kingdom is correct when based on the number of its population.

## Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 307H

ROTAL COLLEGE OF SURGEONS OF ENGLAND (Lincoln's Inn Fields, W.O.).—5 p.m.: Dr. G. E. Smith: The Evolution of the Brain. (Arris and Gale Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Obendes Street, W.O..—4 p.m.: Ar. M. White: Clinque (Surgical). 5.15 p.m.: Lecture: Dr. C. Riviere: The Diagnosis and Therapeutic Use of Tuberculin.

NORTH-EAST LONDON POST GRADUATE COLLEGE (Prince of Walea's General Hospital, Tottenham, N.).—Clinics: 2.30 p.m.: Medical Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meschen); Eye (Mr. R. P. Brooks).

TRURBAR, JULY 18T.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Obenies Street, W.C.).—4 p.m.: Sir Jonathan Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture: Dr. J. Collier: Aphasia according to the New Doctrine (illustrated by cases).

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Walea's Greeral Hospital, Tottenham, N.).—2.30 p.m.: Gymeological Operations (Dr. A. E. Giles). Clinics: Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. H. W. Carson); X-Rays. (3 p.m.: Medical In-patient (Dr. G. P. Chappel).

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NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic: Surgical Out-patient (Mr. H. Evans). 2.50 p.m.: Operations (Mr. W. Edmunds). Clinics: Medical Out-patient (Dr. A. G. Auld); Eye (Mr. R. P. Brooks). 3 p.m.: Medical In-patient (Dr. B. M. Leslie).

CENTRAL LONDON TEROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—3.45 p.m.: Lecture: Dr. A. Wylie: Larynx.

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Salary £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary,
North Street, Leeds.

South Devon and East Cornwall Hospital, Plymouth.—House
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Berks County Asylum, Wallingford.—Second Assistant Medical
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The Hospital for Slot Children, Great Ormond Street, London, W.C. —A House Physician. Salary £30, washing allowance £2 10s., and board and residence in the Hospital. Applications to the Secretary.

board and residence in the Hospital. Applications to the Secretary.

ds University.—Faculty of Medicine.—Demonstrator of Physiology in the School of Medicine. Salary £150 per annum. Applications to the Registrar of the University.

nterbury Borough Asylum, Canterbury.—Assistant Medical Officer. Salary £140 per annum, with board, lodging, washing and attendance. Applications to the Medical Superintendent.

tendent.

8. Mary's Hospital for Women and Children, Manchester.—House Surgeon for six months from July. Homorarium, £25, with board and residence. Applications to the Secretary. (See advt.).

8t. John's Hospital for Disease of the Rin.—Homorary Assistant Physician. Applications to Geo. A. Arnaudin. (See advt.)

DUNN.—On June 23rd, the wife of H. Peroy Dunn, F.R.C.S., of 54 Wimpole Street, W., of a son.
GAVIN.—On June 22rd, at the Medical Mission Home, Anand, Western India, the wife of Neil M. Gavin, F.R.C.S.Edin., of

### Marriages.

GIEDLESTONE—CHATTERTON.—On June 28th, at the Parish Churchof Wimbledon, Gathorne Esbert Girdlestone, M.A., B.M. (Oxon).
M.B.C.S., to Ina Mabel, second daughter of George Chatterton, Esq.,
J.P., of Grovenor Hill, Wimbledon.

PORTER—DECK.—On June 16th, at St. Andrew's Church, Summer
Hill, N.S.W., Douglas David Porter, of the Egypt General
Mission, third son of Joseph James Porter, of Hutton, Essex,
to Olive Lucia, fourth daughter of J. Field Deck, M.D., of
Ashfield, N.S.W.

#### Beaths.

CRUESEMANN.—On June 24th, at the St. Hedwig's Krankenbaus.
Berlin, Dr. Eduard Cruesemann, of Westbrook, Alleyn Park,
Dulwich, and 85 Grasschurch Street, London, in his 54th year.
CUNNINGHAM.—On June 23rd, at 18 Grosvenor Crescent, Edinburgh
Daniel John Cunningham, Professor of Anatomy. Edinburgh

Daniel John Unningham, Professor of Anatomy, Edinburgh University.

BENDLE.—On June 23rd, at Caton, lvybridge, S. Devon, Edmund Marshman Bussel Rendle, M.R.C.S., L.R.C.P., late of 11 Athenseum Terrace, Plymouth.

SHAW.—On June 23rd, at Glastonbury, Kew Gardens, Laura Ellen, widow of the late Archibald R. Shaw, M.D., of St. Leonardson-Sea, aged 75.



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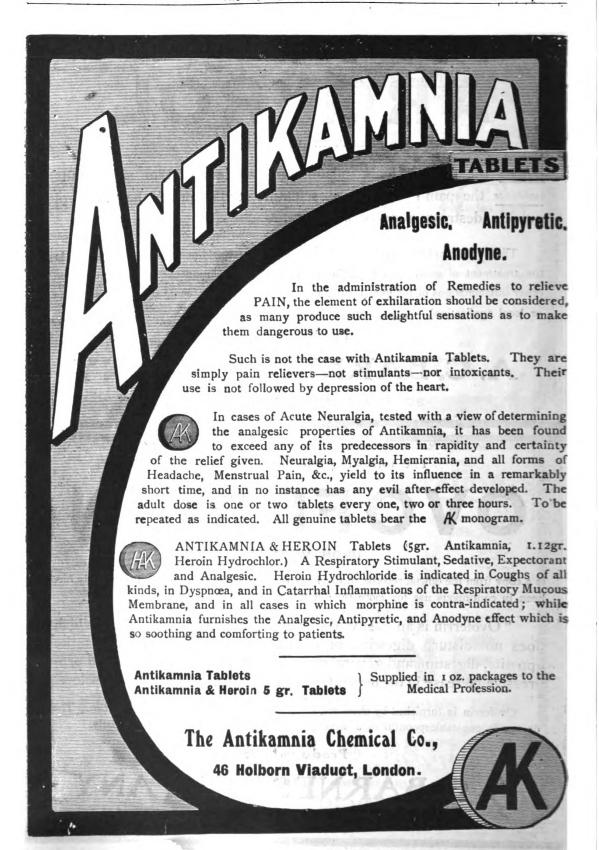
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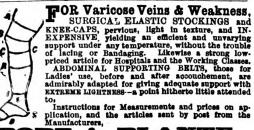
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